DOCUMENT RESUME

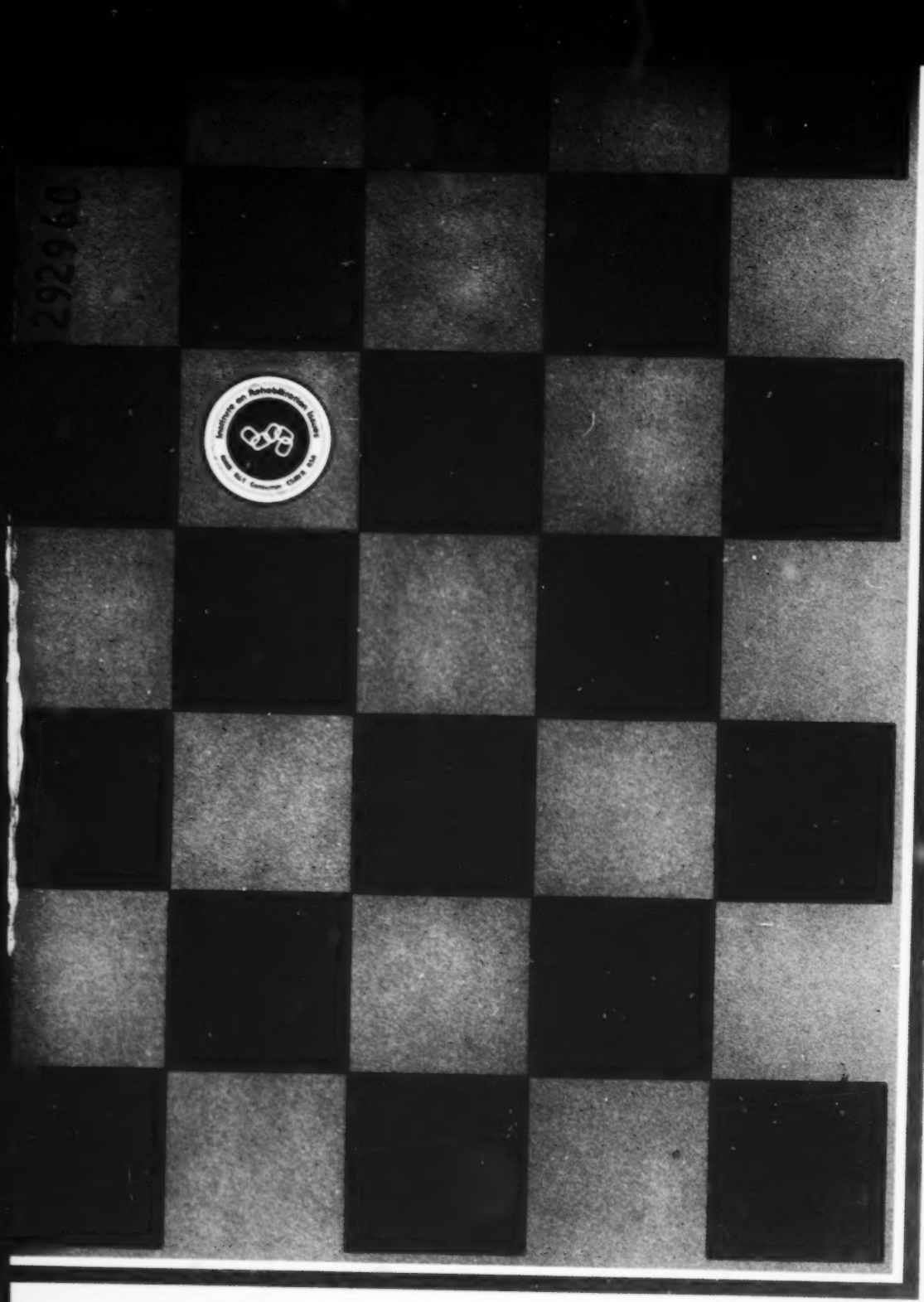
ED 292 960 CE 049 880

AUTHOR	Hope, Robert; And Others
TITLE	Multidisciplinary Approach to Rehabilitation. Report from the Study Group. Institute on Rehabilitation Issues (13th, Little Rock, Arkansas, October 1986).
INSTITUTION	Arkansas Univ., Hot Springs. Arkansas Rehabilitation Research and Training Center.
SPONS AGENCY	National Inst. on Disability and Rehabilitation Research (ED/OSERS), Washington, DC.
PUB DATE	86
GRANT	G0083C0010/05
NOTE	89p.
AVAILABLE FROM	Publications Department, Arkansas Research and Training Center in Vocational Rehabilitation, P.O. Box 1358, Hot Springs, AR 71902 ($6.00).
PUB TYPE	Guides - Non-Classroom Use (055) -- Tests/Evaluation Instruments (160)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Administrator Role; Counselor Role; *Delivery Systems; Educational History; *Educational Improvement; *Educational Innovation; *Interdisciplinary Approach; Postsecondary Education; Program Administration; Teaching Methods; *Vocational Rehabilitation

ABSTRACT

This manual is the response of a National Institute on Rehabilitation Issues (IRI) Prime Study Group to charges given to the group by the National IRI Planning Committee to develop a meaningful training and resource document on the multidisciplinary approach to vocational rehabilitation. The guide is organized in seven chapters that cover the following topics: (1) the historical development of the multidisciplinary approach to rehabilitation; (2) the multidisciplinary approach: implications for leadership in the national program; (3) state vocational rehabilitation administrators: response to a changing environment; (4) management for the future: a priority; (5) the counselor's role in the multidisciplinary approach; (6) impact on service delivery; and (7) improving rehabilitation programs through networking. A reference list is also included. Appendixes include the study group membership list, a list of organizations concerned with vocational rehabilitation program development, an outline of counselor techniques for case management, and a summary of the "Valley Project," a demonstration of multi-agency services considered to be a model for transitional services from school/institution to community. A marketing audit for a job development and placement program is also provided. (KC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****



292960

Study Group Chairperson

Robert Hope
Division of
Rehabilitation Services
1401 Brookwood Drive
P.O. Box 3781
Little Rock, Arkansas

University Sponsor

B. Douglas Rice
Arkansas Research &
Training Center In
Vocational Rehabilitation
University of Arkansas
P.O. Box 1358
Hot Springs, Arkansas

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL IN **MICROFICHE ONLY** HAS BEEN GRANTED BY

R Varley

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Arkansas Research &
Training Center In
Vocational Rehabilitation

University of Arkansas

Arkansas Rehabilitation
Services

CE049880

Report from the Study Group on

Multidisciplinary Approach to Rehabilitation

Thirteenth Institute on Rehabilitation Issues

October 1986
Little Rock, Arkansas

Published By

**Arkansas Research & Training Center
in Vocational Rehabilitation**

Design & Production

Media Materials Development & Dissemination Unit

The contents of this publication were developed under a research and training center grant (G0083C0010/05) from the National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services; Department of Education, Washington, D.C. 20202. However, these contents do not necessarily represent the policy of that agency, and you should not assume endorsement by the Federal Government.

All programs administered by and services provided by the Arkansas Research and Training Center in Vocational Rehabilitation are rendered on a nondiscriminatory basis without regard to handicap, race, creed, color, sex, or national origin in compliance with the Rehabilitation Act of 1964. All applicants for program participation and/or services have a right to file complaints and to appeal according to regulations governing this principle.

Table of Contents

Acknowledgments v

Introduction to the Study 1

Chapter One
The Historical Development of the Multidisciplinary Approach to Rehabilitation .. 7

Chapter Two
The Multidisciplinary Approach:
Implications for Leadership in the National Program 13

Chapter Three
State Vocational Rehabilitation Administrators:
Response to a Changing Environment 21

Chapter Four
Management for the Future:
A Priority 29

Chapter Five
The Counselor's Role in the Multidisciplinary Approach 35

Chapter Six
Impacting Service Delivery 41

Chapter Seven
Improving Rehabilitation Programs Through Networking 53

References 61

Appendices 67

- Appendix A: Prime Study Group
- Appendix B: Total Study Group
- Appendix C: Organizations Concerned with Policy Making and Program Development
- Appendix D: Marketing Audit for a Job Development and Placement Program
- Appendix E: Basic Counselor Techniques for Effective Case Management
- Appendix F: Cooperative Agreement Between Martha Walker Community Center and Vocational Rehabilitation
- Appendix G: The Valley Project

Acknowledgments

The development of this IRI document was an educational and challenging experience. Today, the need for quality rehabilitation services demands the use of resources available through a multidisciplinary approach. A number of agencies have already implemented innovative approaches through which individuals with severe disabilities are being served in a more efficient manner. Although these programs vary in scope, they all have as their objectives the delivery of effective services within a shorter time frame while serving a large number of the handicapped population as a reasonable cost.

The ultimate success of the multidisciplinary approach to rehabilitation will depend upon many factors including administrative commitment, staff attitudes, and the availability of professional staff, services and funding.

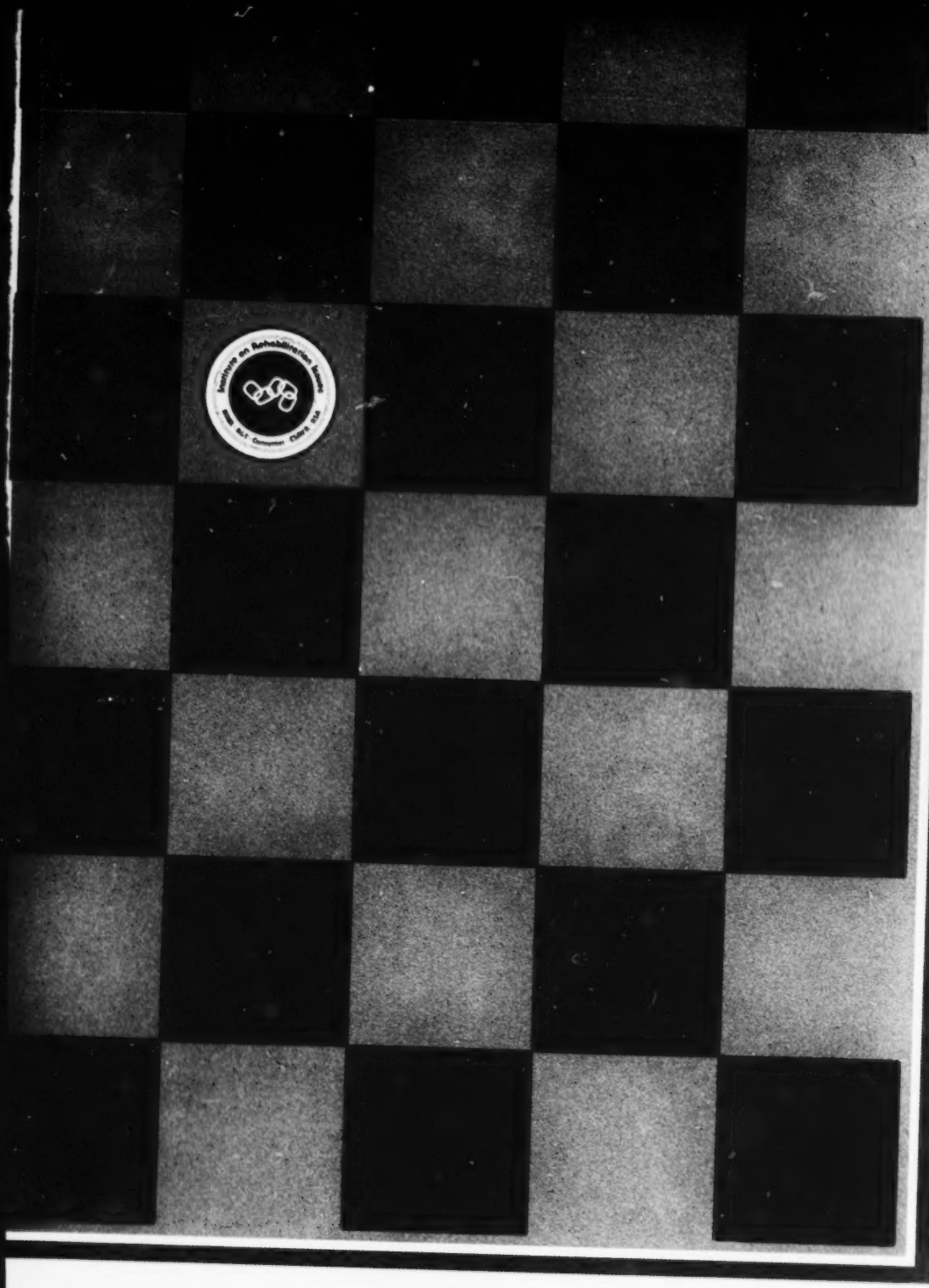
The Prime Study Group has responded to the charges developed for this document by the National IRI Planning Committee. For the many hours of time and effort outside their normal areas of responsibility, I extend my sincere thanks and gratitude. The members of the Prime Study Group were: Bob Losin, Michigan Rehabilitation Services; Carol Cato, Arkansas Rehabilitation Services; Harold Thomas, Arkansas Rehabilitation Services; Greg Solum, Missouri Division of Rehabilitation; Jon Schuch, University of Virginia Medical Center; Marvin L. Tooman, Iowa Rehabilitation Education & Services Branch; Wayne Sanders, Texas Rehabilitation Commission; William (Doc) Williams, Tennessee Division of Rehabilitation Services.

A very special thanks to Dr. Douglas Rice of the Arkansas Research and Training Center in Vocational Rehabilitation for his leadership in keeping the study group on task and in meeting all deadlines. Many others have made real contributions in completing the study. Appreciations are extended to Sandra Parkerson, Ruth Gullett and Carolyn Langston of ARTC-VR for their support and assistance. Sincere thanks to Janice Davis who typed and retyped many copies of this document in preparation for final printing.

In this study we have attempted to address the major issues and provide some answers to the many questions regarding the multidisciplinary approach to rehabilitation.

The Prime Study Group is aware that this document is only a beginning effort and much remains to be done before the multidisciplinary approach becomes a widely used and accepted practice in providing services to individuals with disabilities.

Robert C. Hope
IRI Study Group Chairman
Arkansas Rehabilitation Services
Little Rock, Arkansas



Introduction to the Study

Introduction to the Study

Rehabilitation as a professional entity is becoming more demanding and complex with development of new technologies, explanding client populations and implementation of new program priorities. Because of these demands and complexities, rehabilitation professionals must make use of all available resources to ensure that the total needs of clients are being met. Further, traditional roles and responsibilities of staff are changing along with the changes in rehabilitation. Today's rehabilitation clientele demands full use of all services, resources, and expertise available from various agencies. A number of agencies/organizations throughout the country are in the process of implementing cooperative programs and innovative approaches which will serve individuals who are handicapped in a more efficient manner. Many programs involve not only rehabilitation services but Special Education, Developmental Disabilities, Vocational Education and other organizations with intervention taking place with the client at an earlier age. Recent National initiatives and priorities on supported employment and transition from school-to-work are good examples of the multidisciplinary approach to services for persons with disabilities. Although these and other programs vary considerably, all have as their major objectives the provision of better services to a larger number of deserving clients at more reasonable costs both in funds and time. The multidisciplinary approach has existed in rehabilitation for a long time but has not usually involved other agencies to a great extent. Expanding client populations and the cost of doing business mandates that a multidisciplinary approach be implemented.

The IRI Study

The potential benefits of the multidisciplinary approach in rehabilitation were identified by disciplines from across the country as a major issue. When funding and resources are real problems, agencies realize that they must use available resources in the most efficient manner possible. Because of these concerns, this topic was selected by the National Institute on Rehabilitation Issues (IRI) Planning Committee for study and subsequently assigned to the Arkansas Research and Training Center in Vocational Rehabilitation for development and dissemination.

Purpose

Much has been written about the multidisciplinary approach to rehabilitation in providing services for clients with disabilities. There is little evidence, however, that this information has been disseminated widely to the field. Therefore, the intent of this IRI Study Group was to develop a document emphasizing use of the multidisciplinary approach and to disseminate the publication to a broad audience of rehabilitation personnel and others in related fields and/or organizations.

The IRI Study Group debated as to the best process for developing a meaningful training and resource document on the multidisciplinary approach. Eventually it was the concensus of the Study Group to review some exemplary projects in operation in rehabilitation and to devote attention to the need

for involvement by such agencies as Special Education, Developmental Disabilities, Vocational Education and others. This involvement by other disciplines as well as rehabilitation personnel in terms of program priorities and new client populations will become even more critical as other programs and populations are added.

The IRI Prime Study Group realizes this document cannot be all inclusive regarding the multidisciplinary approach for much remains to be done in the area of coordination of services for persons with disabilities. Effective use of personnel from various agencies/organizations will be a continuous and evolving process and as a result there will never be one established or set procedure.

Charges to the Study Group

The National Institute on Rehabilitation Issues Planning Committee gave the Prime Study Group the following charges:

1. Develop a document to assist state rehabilitation agencies and other related organizations to plan, initiate and use multidisciplinary approaches to better serve persons with severe disabilities.

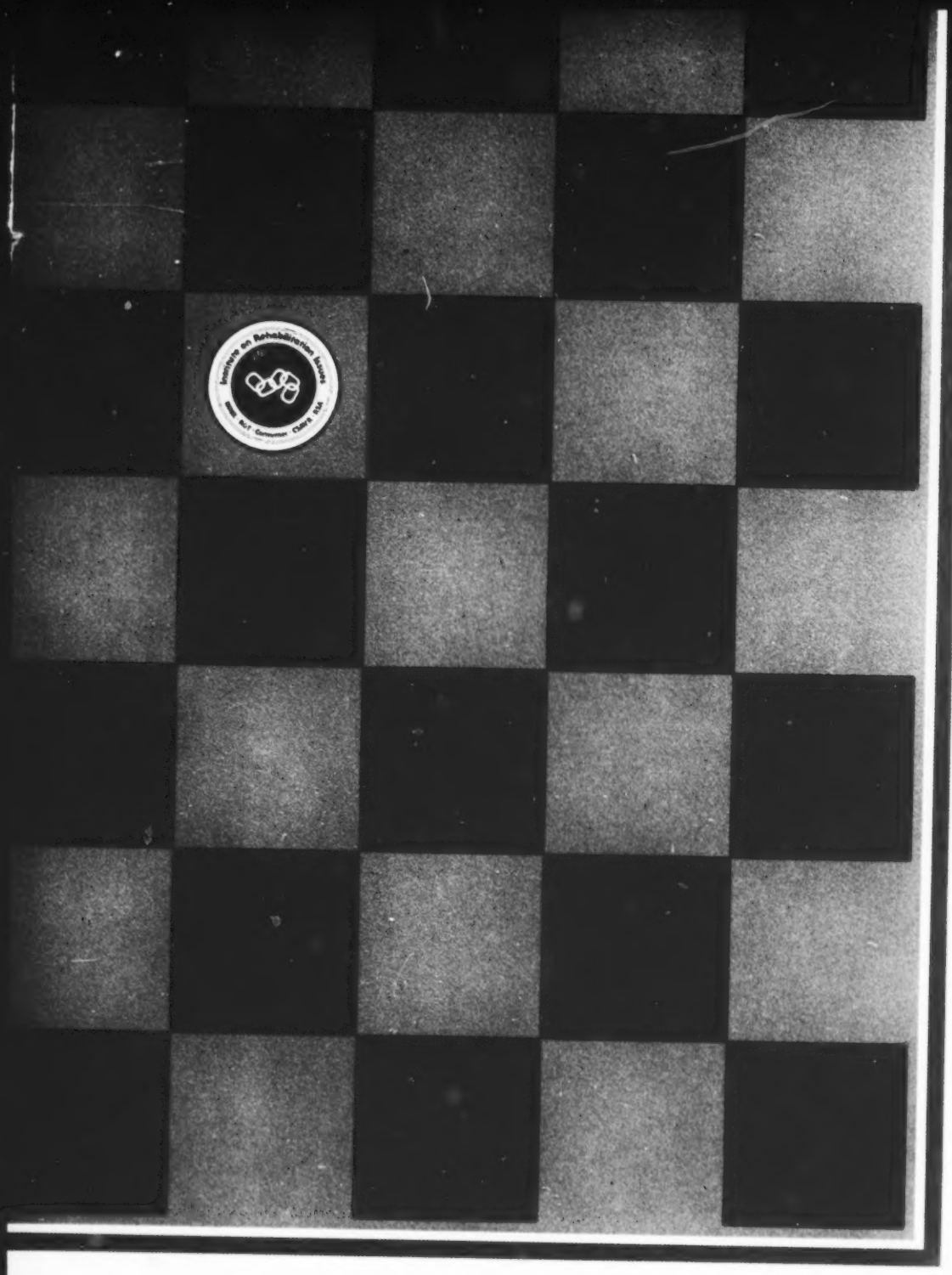
2. Create a resource document which can be used for training purposes by staff development personnel, Regional Continuing Education programs, Rehabilitation Education and other trainers to increase the knowledge, awareness, and skills of professionals in the field on the multidisciplinary approach in the Rehabilitation Process.

The IRI Study Group has attempted to meet these charges through the materials presented in this manual. The final evaluation of this group's efforts will be determined by the usefulness of this document in implementing multidisciplinary approaches within rehabilitation and other related agencies/organizations.

Projections

The future is uncertain. Indications are, however, that rehabilitation agencies will be expected to provide quality service to more clients on funding levels similar to those now being received. Assignments of this nature are nothing new as agencies over the years have accepted new challenges and have responded to these tasks successfully. To meet these challenges there are many implications for rehabilitation agencies including training of personnel in the use of the multidisciplinary approach, and the development of relationships with employers, schools, consumers, and other agencies. There will be a need for coordinated efforts among agencies not only to provide better services, but to share costs and personnel in order that persons with disabilities can be served more effectively.

This Prime Study Group has devoted many long and arduous hours to the development of this manual. It is the hope of this group that the document will prove to be a valuable asset to rehabilitation in the implementation of multidisciplinary approaches.



Chapter
One

The Historical Development of the Multidisciplinary Approach to Rehabilitation

Rehabilitation agencies, like other agencies, sometimes succumb to the inertia of tradition. Since the program is not under attack in any substantial way from any large segment of the population, it may seem best not to "rock the boat." Yet there is a real danger that rehabilitation may lose its freshness of approach, its pioneering spirit, its willingness to venture into untried areas, unless it consciously and with determination resists the forces that would keep it as it is.

Javits, 1969

Objectives

To present a brief background regarding the growth and development of the rehabilitation movement in this country.

To emphasize that rehabilitation has frequently used (but never fully advocated) the multidisciplinary approach in serving persons with disabilities.

Summary

Throughout history rehabilitation has promoted a multidisciplinary approach to services. However, today's complex and rapidly changing society and the subsequent expansion of rehabilitation programs to accommodate exploding client populations requires us to take an indepth look at our past and to project our needs for the future.

Discussion

The history of rehabilitation can in itself be viewed as a reflection of the growth and development of the multidisciplinary approach. The need for contributions from specialists in the rehabilitation process became apparent with the realization that rehabilitation counselors needed special information and consultation to provide appropriate services to persons with disabilities. Following the success of the Soldier Rehabilitation Act of 1918, the Smith-Fess Act of 1920 encouraged states to undertake similar legislation and provide similar services for persons with disabilities.

As a result of the Great Depression of the 1930's a dramatic shift occured in public values. An expanded role for the federal government into various aspects of American life became necessary to control the economic and political forces that led to this economic disaster.

The administration of President Franklin D. Roosevelt promoted the passage of legislation and the development of programs designed to assist with a variety of domestic social problems in this country affecting both the general population and persons with disabilities who found themselves without adequate work, food, shelter, and basic medical care. The formation of private, non-profit organizations representing national issues and the evolving federal-state partnership of service programs were outgrowths of these national concerns.

The formation of the National Rehabilitation Association (NRA) in 1927 provided the needed forum to expand the nation's vocational rehabilitation programs for citizens with disabilities. Accomplishments of NRA through the years include a series of amendments to the Rehabilitation Act which have enhanced the Federal-State Program of Rehabilitation and have underscored the need for a multidisciplinary approach.

The first major change in the national rehabilitation program came about under Public Law 78-113 of 1943 which increased funding, expanded the scope of services, and extended the program to citizens with mental disabilities. As public awareness about rehabilitation programs increased there were greater demands for more services to new client populations previously unserved.

Throughout the 60s, services were expanded to such groups as welfare recipients, juvenile delinquents, prison populations, alcoholics and others. These populations required more auxiliary services to assist the rehabilitation counselor. For example, using the rehabilitation model to serve welfare recipients required the use of disciplines not normally used in the traditional approach. With these clients, it was necessary for rehabilitation counselors to integrate all possible services and resources.

Although funding was an issue, demand for services was still high when the Rehabilitation Act of 1973 emphasized serving persons with severe disabilities. Experience indicated that the rehabilitation model was the best vehicle to serve persons with severe disabilities using a multidisciplinary approach. The passage of the 1973 Act ushered in a new era for the program which dictates new methods and techniques for persons with disabilities that will be served in the future. The United States is experiencing a technological, economic, political and cultural transition which is creating severe competition among human service programs for the social service dollar.

The basic program as defined in the orginal Smith-Fess Act of 1920 (Civilian Vocational Rehabilitation Act) remains essentially unchanged. Services have been expanded and rehabilitation today serves a more diversified client population. For this reason and for the many accolades the rehabilitation program has recieved in the past, it is difficult for many people to see a need to change. But the provision of vocational rehabilitation services has become more complex over the years. These changes, as a result of consumer demand and federal legislation, have made the rehabilitation counselor's job more complex. The use of additional support staff will require VR agencies to modify the traditional model in order to be more responsive to the needs of individuals with severe disabilities. Some of the issues that will need attention and action are:

1. The service delivery model which will facilitate the rehabilitation process;

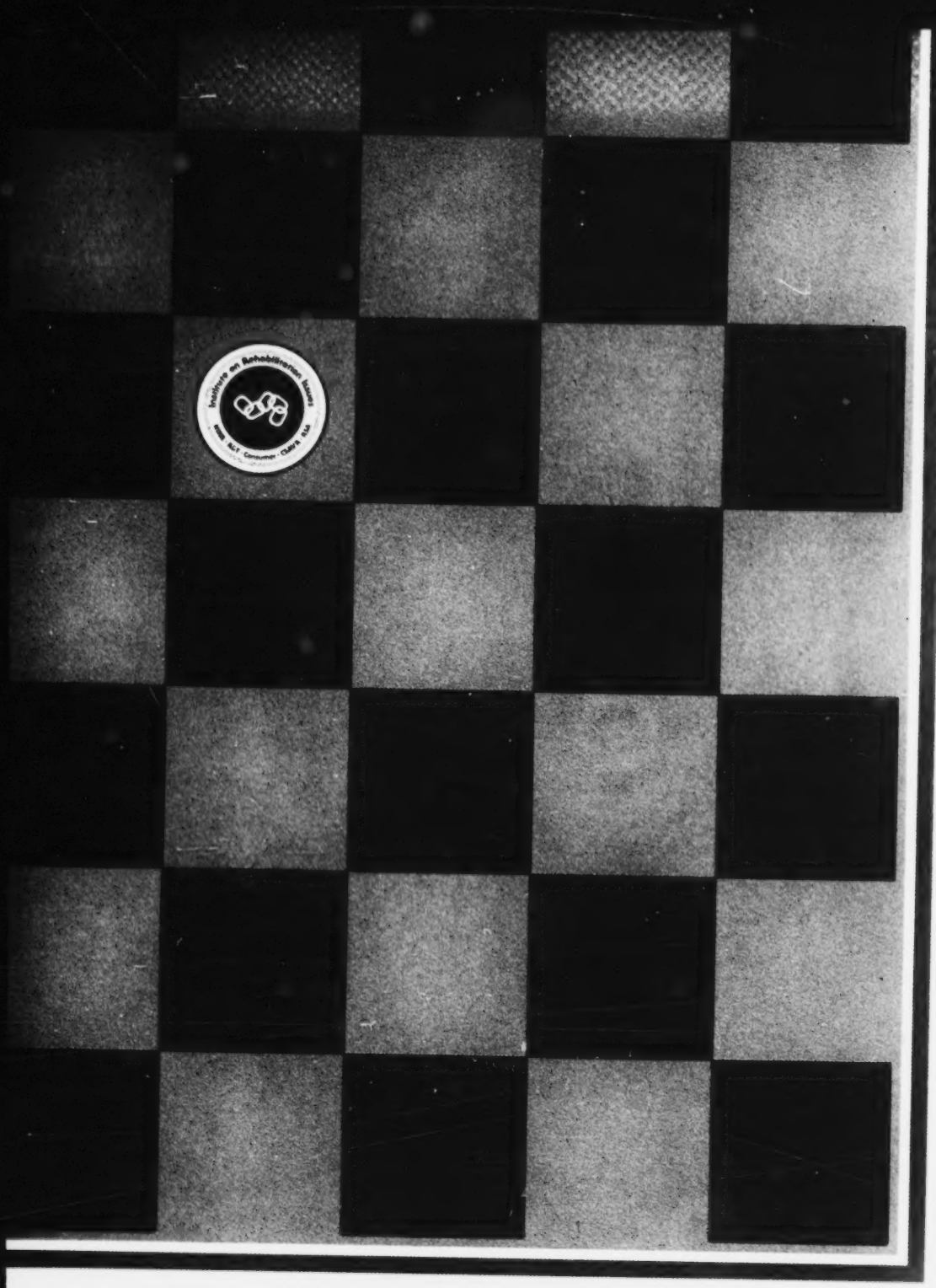
2. The case management system to better use the multidisciplinary approach;

3. Networking strategies;

4. Agreements between vocational rehabilitation and other appropriate agencies; and

5. Disincentives that prevent people with disabilities from accessing rehabilitation services;

The above issues are difficult tasks but are critical concerns that must be addressed. Nevertheless, rehabilitation has been challenged many times and in many ways before. Without question, rehabilitation will be equal to this task as it has been in the past.



Chapter
Two

The Multidisciplinary Approach: Implications for Leadership in the National Program

Professionals must continue to refine what they **know** and improve what they **do**, all the while acknowledging the fact that citizens with disabilities **will** express what they want and desire from those who serve them. This new reality is based on mutual respect, communication, shared power, and the democratization of our field. In terms of our history and our present, nothing less will do for our future. National rehabilitation policy must be based on this multidisciplinary approach.

Objectives

To discuss program and policy conflicts that result from contrasting views of disabilities and definitions.

To identify the need for a comprehensive effort to integrate the input of various interest groups, professionals, consumers, employers, and legislators into national goals, policies, and programs which are consistent and complement each other.

To review the implications of the multidisciplinary approach as a problem-solving strategy for policy development by vocational rehabilitation program leaders and administrators.

To clarify the reasons why multidisciplinary approaches to problem solving/policy making must be in place at all organizational levels in order to be effective.

Summary

The challenge to rehabilitation leaders to develop new strategies for the pursuit of legitimate special interests and the integration of effort to achieve broad, national goals is reviewed.

The relationship between multidisciplinary concepts and processes at the leadership level to the roles and behaviors of supervisors, support staff, and rehabilitation counseling staff are also discussed.

The advent of consumerism and the sharing of power in determining the future of the rehabilitation program is a key element in charting the program's future course.

The role of special interest groups and the dilemma they pose for the development of comprehensive policy is presented, as well as potential remedies for this problem.

Various mechanisms for developing national policy are reviewed, as well as some observations regarding the opportunity for successful leadership groups like the Council of State Administrators for Vocational Rehabilitation (CSAVR), the National Rehabilitation Association (NRA), and the National Association of Rehabilitation Facilities (NARF) to focus their leadership energies and skills on the development of a national policy of service to citizens with disabilities.

Discussion

A. The Need for Integrative Leadership

Clearly the decade of the 80s might be described as the period of transition and change for the rehabilitation program. Reduced funding, competition from other programs, and increased demand for results are

realities which cannot be ignored. The effort to change and adapt the Federal-State Program to this new set of realities cannot occur in isolation. The change will have to be based on far-reaching efforts which are designed to coordinate and reflect the input, interests, needs, and wants of all sub-markets of the rehabilitation industry. This will produce a comprehensive and effective set of program services which enable the nation's citizens with disability to lead a more fulfilling life.

The primary focus of this document deals with the application of multidisciplinary approaches at various levels in the Federal-State Program, as well as other organizations. Multidisciplinary approaches to service delivery, however, cannot be created or sustained without leadership and support. These multidisciplinary approaches must be the expression of values made manifest by program leadership. Counselors, supervisors, and managers must be able to recieve direction and support from the highest levels in their organizations in order to establish and maintain multidisciplinary integration at the service delivery level. Multidisciplinary approaches, therefore, cannot be grafted onto the existing system, but must become characteristic of individual and organizational activities at all levels. In this way, the system will support individual efforts, as well as be shaped by them.

Counselors, and/or service delivery managers will be more successful in implementing multidisciplinary approaches if the way for these approaches has been paved by leadership. These policies and programs enhance and support collaboration at the local level. Integration of goals, objectives, resources, and processes become possible when leaders share common values and recognize the benefits from integrated planning and multidisciplinary approaches to problem solving and provide incentives for this accomplishment. This view that change must begin at the top is the major implication of this chapter.

B. Civil Rights and the Emergence of Consumerism

The active role of consumers in shaping program goals and policies is another implication for rehabilitation leadership. In the early 60's minority groups were pressing for full civil rights through national campaigns of political action and civil disobedience. These activities culminated in the passage of the Civil Rights Act of 1964. In 1973, similar antidiscrimination legislation for America's disabled population was enacted by Congress as a part of the Rehabilitation Act of 1973.

Success resulting from the civil rights movement prompted action by advocates for the disabled. Consumers of rehabilitation services and their advocates began voicing their concerns and refocusing the future programs. Consumer impact can be seen in the Rehabilitation Act provisions for the Individualized Written Rehabilitation Program (IWRP) and Client Assistance Programs (CAPs). Consumer involvement also contributed to emphasis on equality in access to public buildings and programs, the right to self-determination, and the right to exercise personal choice in determining one's future.

C. Minority Definition of Disability

The consumer movement also focused attention on the environmental and societal barriers to the success of their group members. Consumers saw their situation as similar to that of ethnic and racial minorities whose task of assimilation into the majority culture was impeded not only by their individual differences, but by a series of societal and environmental barriers as well.

This minority view of disability, when combined with the functional limitation definition, has broad implications for rehabilitation service providers and planners. It increases the breadth and complexity of issues issues to be addressed. Hence, it requires the talents, insights, and contributions of diverse individuals.

This will require multidisciplinary (including consumer) approaches to policy development, programming, and resource allocation. This will ensure that comprehensive understanding of the issues leads to an expanded array of effective service interventions. McConnell (1984) states:

> Practitioners in Rehabilitation must also become experts in the areas of environmental accessability, job accommodation, laws protecting the handicapped, and assuring education and awareness of the general public. This speaks to an enlarged role for Rehabilitation practitioners.

This expanded view of disability also has implications for new populations to be served as well as the need for new and different services, i.e., independent living, transition from school to work, and supported employment.

The need for rehabilitation services was stimulated by passage of legislation which required that employers and their insurance carriers assume responsibility for rehabilitation services to injured workers. Subsequently, coverage was also extended to auto insurance companies and long-term disability insurance underwriters which resulted in the growth of the private sector segment of the rehabilitation industry. In contrast to the common belief, private-for-profit service providers are not competing alongside public and private nonprofit providers for clients and resouces. Like the consumer movement, the private sector has challenged the prerogatives of the Federal-State Program for leadership control of the rehabilitation industry in this country. Thus, the need for collaborative planning and decision making with the private providers is clear. This will ensure that client needs are met and that all markets are covered.

A comprehensive national policy would provide the initial direction and agreement, as well as ensure integrated noncompetitive approaches to

serving various client markets. It would significantly improve effectiveness by ensuring a balance between service capacity and need promoting greater equity of opportunity to citizens with disabilities.

D. A National Policy of Service to Citizens with Disabilities

The need for a comprehensive national policy of service to citizens with disabilities has been documented in the literature by a variety of authors (Berkowitz, 1985; National Council for the Handicapped, 1984).

Berkowitz (1985) says that the various meanings of disability have evolved over time and have served to make the development of a comprehensive policy a most difficult task.

> On one level disability refers to the damages that one group of people collects from another as a result of insult or injury, although the courts and litigations serve as the usual means of transferring money from the responsible to the disadvantaged, many other mechanisms exist for this purpose. Private insurance and social insurance come to mind as do specific disability programs that use a combination of these approaches...on the second level disability means the state that lies between ill health and unemployment, which gives rise to many policy devices and programs.

Berkowitz cites a third distinctive meaning of disability which involves the idea of imposed handicap.

> These are people who were born or who acquired a mental or physical impairment or limitation in function that immediately identifies them as belonging to a distinctive group of individuals. This definition of disability ...differs from the first two in that persons with disabilities do not choose to be handicapped; society imposes this label on them.

Berkowitz points out that public policy toward this group has undergone a change from emphasizing custodial care to one of training for independent living, employment, and self-determination. It is his contention that these definitions are the basis for the specific form and breadth of policy and programs designed to serve persons with disabilities.

An additional dilemma suggested by Berkowitz which relates to the fact that existing program structures and practices limit the amount of change and innovation possible. While he acknowledges that the rehabilitation program has made several adjustments in its history to changing environmental conditions and grants, he nonetheless underscores what appears to be a realistic inhibitor of future change by pointing out,

> ...the program's core identity as designed by the characteristics it acquired in the 1920s remains in place...each has an identity that gives it a certain inflexibility in pursuing modern objectives. As new objectives arise, new programs get placed on top of one another, further complicating the institutional landscape and making public policy toward disability more difficult to comprehend.

He suggests that future trends in disability policy will take the following form:

1. A greater reliance and experimentation with the private sector as a source for rehabilitation services;

2. A strengthening in the concept of entitlement as regards income maintenance programs;

3. An evolution of a more progressive social policy based in large measure on what people with disability think is right for them.

E. National Policy Mechanisms

There is a significant opportunity for the leadership of organizations such as Council of State Administrator in Vocational Rehabilitation, National Council for the Handicapped, National Rehabilitation Association, and National Association of Rehabilitation Facilities to play a role in developing a comprehensive national policy. For a description of these organization see Appendix C.

Conclusion

It is clear that policy must be based on the needs of the various markets subsumed under the title of rehabilitation and based on a recognized value which affords the citizen with disability the central and dominant voice in the market network.

Professionals must continue to refine what they know and improve what they do, all the while acknowledging the fact that citizens with disability will express what they want and desire from those who serve them. This new reality is based on mutual respect, communication, shared power, and the democratization of the rehabilitation professional. In terms of our history and our present, nothing less will do for the future. A national rehabilitation policy must be based on a multidisciplinary approach.

Chapter
Three

State Vocational Rehabilitation Administrators: Response to a Changing Environment

The new opportunities that are before us... are so far reaching and in some ways so fearsome, that it would be easy to take advantage of the legislative opportunities that we have been given in the last year and feel good about the job we are doing.

Switzer, 1967

Objectives

To point out that rehabilitation agencies/organizations have and will continue to undergo dramatic changes in terms of client populations, personnel needs, funding, job markets, and external pressures.

To emphasize that the complexity of present day rehabilitation services demand that administrators actively seek out new strategies to meet the challenges which threaten the basic structure of the state-federal program.

To present marketing as a concept for the consideration by administrators to meet many of the challenges confronting rehabilitation, expecially those related to the employment community and the placement of qualified employees with disabilities.

Summary

The implications discussed in the previous chapter suggest that the public vocational rehabilitation program is entering a period of unprecedented change. There has been substantial increase in the competition between service programs for diminishing resources and dollars. In responding to these challenges, there is a growing sense of urgency among rehabilitation administrators. After years of continuous growth, the public rehabilitation program appears now to have entered a crucial period. There is a critical need for effective use of resources in response to decreasing funding. Failure to address this need risks the decline of a viable public human service program, as well as the loss of the skills and talents of millions of deserving Americans with disabilities.

Discussion

Living With Our Past - The experiences of current vocational rehabilitation administrators are dramatically different from those of their predecessors of 20 years ago. In 1967 Mary Switzer alluded to the gains made by rehabilitation since its inception. However, she cautioned administrators not to be content or complacent with all the progress made and to prepare and plan for even greater changes and challenges in the future. Almost two decades ago, Hunt (1969) stated that for the first time in history, over 200,000 persons were rehabilitated in the 12 months ending June 30, 1968. Also, he noted in the ten-year period from 1958 to 1968, the number of rehabilitants increased 180 percent--almost threefold--from 74,317 to 207,918 people. Despite those glowing proclamations about the VR program, the late Senator, Jacob K. Javits, an early benefactor of the program echoed Ms. Switzer's fears about the future and concern about agencies losing their pioneering spirit.

Beginning in 1974 and running through 1984, the number of persons rehabilitated indicated a decline in numbers from year to year. Further, the total number of persons served by rehabilitation services (not just those rehabilitated) continued to decline through 1985. The decline in the number of clients served was, in part, attributed to the decline in the purchasing power of the rehabilitation dollar and the increased commitment to persons with severe

disabilities. It is evident from the information above that over the last 30 years, the rehabilitation movement has experienced a cycle of growth and decline. Although there has been some moderation in rehabilitation statistics, it is doubtful that another period of substantial or rapid growth will take place.

As rehabilitation programs grew through the late 60s and early 70s, they became increasingly demanding and complex. Peters (1982) noted that large complex organizations tend to design complex systems and structures. They then hire more staff to keep track of all this complexity, and Peters suggests that that's where the mistake begins. People aren't sure to whom they should report and for what.

> The organization gets paralyzed because the structure not only does not make priorities clear, it automatically dilutes priorities. In effect, it says to people down the line: Everything is important, pay equal attention to everything. The message is paralyzing. (Peters & Waterman, 1982).

The forecasts by Switzer and Javits may be emerging realities. External critics of vocational rehabilitation programs, including other human service agencies, consumers, the private sector and other organizations, are on the increase. As a result of this criticising, rehabilitation administrators have responded in many positive ways, including the adoption and implementation of the marketing concept.

A Vocational Rehabilitation Administrator's Response to Marketing - Recent rehabilitation literature has reflected increased attention to marketing concepts (9th IRI, 1982; 7th Switzer Memorial, 1983; Como & Hagner, 1986; Hawley, Grant, Hagg, Jiang & Montesinos, 1983). The marketing concept has been initiated by some rehabilitation programs with considerable success. In particular, Projects With Industries (PWI) are programs cooperatively administered by private industry business and public/private-nonprofit rehabilitation agencies. Dr. Gopal C. Pati (1982) identified three important functions of PWI's that reflect a marketing orientation as follows:

1. They create an active and effective partnership of business, industry and service agencies in the rehabilitation process;

2. They facilitate the tapping of the great potential of workers with disabilities; and

3. They make rehabilitation services more responsive to the needs of employers (Pati, 1983).

These functions focus on the business community and the needs of employers. Correspondingly, they are compatible with one generic definition of marketing: "The disciplined task of creating and offering values to others for the purpose of achieving a desired response" (Shawhan, 1984). This definition can be applied to consumers, employers, legislators, and taxpayers which

emphasizes use of a multidisciplinary approach. For rehabilitation practitioners knowledgeable about marketing principles, the definition can easily be applied to the needs of employers. The marketing concept, however, has not been universally accepted particularly in rehabilitation counseling. Specifically, Nadolsky (1986) in an article dealing with private rehabilitation, suggests that the purpose of rehabilitation becomes clouded when a major emphasis is placed on meeting the needs of organizations...while de-emphasizing the rehabilitation needs of persons with disabilities.

Defining Mission and Purpose - When Senator Lowell Weicker, Jr. (R-CT), introduced the Senate version of the Rehabilitation Act Extension for 1986, he noted, "The overall purpose of the Rehabilitation Act is to promote employment, an outcome which benefits us all." In 1982, Conn stated, "...our number one priority must be job placement and job development. ...We cannot do rehabilitation without placement in the process." Smits and Emener (1980) stated,

> Remunerative employment of the disabled continues to be the 'raison d'etre' of state vocational rehabilitation agencies, and job placement activities by vocational rehabilitation counselors are still the 'sine qua non' of the vocational rehabilitation process.

These statements after close review, may cause the reader to wonder why, if the purpose of rehabilitation is employment--they need to make such statements regarding placement at all. In contrast, rarely would Lee Iacocca state that the purpose of the Chrysler Corporation is to sell cars. Griswold (1983) recognized that job placement was not receiving the needed emphasis and suggested why this problem existed.

> I'm always somewhat amused that we recharge ourselves by talking of how we should direct our programs to improve placement services. Frankly, I think we've been falling far short of any real improvement of our placement programs. There are a number of things I believe that are causing this shortcoming. At least in my own agency, there has been a period of time when our goals have become very diverse. They have moved from placement to secondary goals and to substitute goals and perhaps even to process goals.

The leadership of any organization must specify its goals and objectives which respond to external needs. As public rehabilitation programs respond to increased criticism, administrators and legislators at both the federal and state levels must provide the impetus to the mission of rehabilitation and its value to persons with disabilities. With a sense of purpose, rehabilitation leaders all across the country must and will transform rehabilitation workers from neutral, technical units into participants who have a deep and sincere commitment to gainful employment of qualified persons with disabilities.

Designing the Tools for Rehabilitation Marketing - Just as rehabilitation administrators reaffirm the program's commitment to employment, and as rehabilitation practitioners gain a better understanding of the meaning and

purpose of their contributions, there is a need to conduct a systematic evaluation of the program's strengths and weaknesses. A marketing audit has been suggested for rehabilitation administrators as a means to assimilate, debate and develop their own concept of needed marketing action (Spann, 1983). A market audit model adapted by Hawley, Grant, Haqq, Jiang, and Montesmos (1983) outlines those questions necessary to audit a rehabilitation agency's current effort toward marketing for job development and job placement. (See Appendix D).

Acknowledging that one of rehabilitation's primary markets is the employment community, rehabilitation administrators will need to respond to that market in a timely fashion and with a high level of qualified applicants with disabilities. Unlike legislators or rehabilitation administrators, employers are not necessarily aware that rehabilitation dollars are diminishing and that rehabilitation services are targeted toward individuals who are severely disabled. Their greatest concern regarding persons with disabilities is "can they do the job?" Additionally, they have concerns relating to the quality of the products (workers), their reliability, and the ability of the supplier to provide follow-up services. If employers can't be satisfied in all these areas, they will turn to another supplier or placement agent.

Rehabilitation administrators, like other business administrators, will need to accommodate their deficiencies so they can remain competitive in the marketplace. Assumptions can't be made that fewer government dollars will mean fewer placements. If the assumption is made, the spiral of decline will continue until someone decides that program dollars can be better spent somewhere else. Creativity and outreach to other disciplines can offer rehabilitation the opportunity of increasing its competitiveness and subsequently, its share of the market. Conforming to a typical marketing model, the tools that are used in meeting the needs of the market center on the product, packaging, price, distribution channels and promotion. The following examples illustrate how rehabilitation might use these tools in better serving its markets:

1. **Product** - Changing the product may mean adding or subtracting to the line or substantially altering the configuration of the existing product. Rehabilitation practitioners may improve the quality of "product" by providing a better link with schools in serving youth with disabilities;

2. **Packaging** - Rehabilitation clients can be distinguished from other recipients of government services (i.e., welfare, etc.). Linkages can be made with national and local media experts to aid in describing clients as qualified job-ready individuals who can meet employers' human resources needs;

3. **Price** - By cooperating with other funding sources (i.e., Job Training and Placement Act and local school districts) rehabilitation can offer on-the-job training (OJT) programs that can reduce an employer's cost of doing business;

4. **Distribution Channels** - Distribution is how a product gets to its market. Combining with other public service employment programs may enable rehabilitation clients to have greater access to employers; and

5. **Promotion** - Publicity, advertising, and public relations can aid in moving qualified persons with disabilities in the marketplace. Cooperation between rehabilitation and a community service club can aid in describing the individual quantities of job-ready persons with disabilities.

These examples illustrate that rehabilitation's effectiveness can be increased through cooperation with other disciplines and service programs. Increased efficiency and effectiveness can occur without necessarily raising the cost of the product.

VR Staffing in Response to Changing Markets - Business and industry executives have become increasingly sensitive to not only their changing markets, but also the narrowing of those markets. For example, auto companies providing of more customized or individualized vehicles, the proliferation of specialty fast food shops, the increased variety of Bible translations, and the expansion of television programs to include special interest areas (i.e., sports, country music, children's shows, & adult features). The mass distribution systems associated with the industrial revolution are being replaced by splintered distribution systems. Futurist Toffler (1980) stated, "the mass market has split into ever-multiplying ever-changing sets of mini-markets that demand a continually expanding range of options, models, types, sizes, colors, and customizations."

Rehabilitation administrators who advocate a marketing model recognize that rehabilitation markets are splintering and there will be a need for continuing services to ensure that those markets have been satisfied. Businesses and industries that have experienced many changes, again, must learn an entirely new way of doing business.

Rehabilitation agencies that view persons with disabilities generically will find an increasing level of dissatisfaction and criticism of their services. If those same agencies consider the employment marketplace as one large forum for their clients, they will experience increased frustration with the placement function in the rehabilitation process.

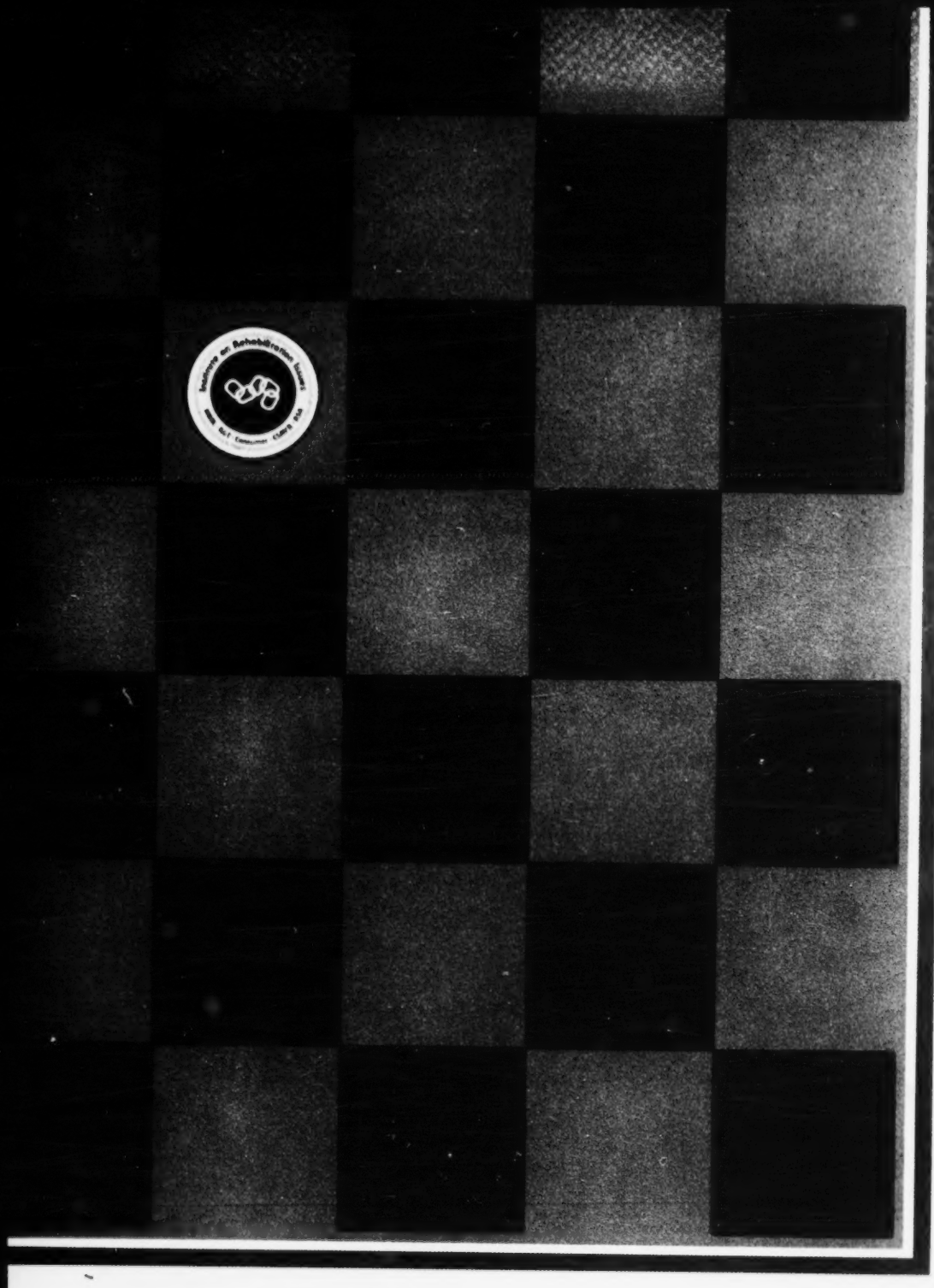
Counselors are often expected to do everything in the rehabilitation process from intake to placement. The counselor has been described by Sinick (1977) as a composite of responsibilities and multidiscipline functions. Once the client's problem has been identified and a strategy selected, the counselor assumes responsibility for coordination of the integrated pattern of services that address the client's needs. Other rehabilitation professionals have suggested that the broad professional involvement of a counselor from client acceptance through case closure is quite desirable.

The fragmentation of rehabilitation markets increases the complexity of the rehabilitation process. Satisfying each of the markets will require the individualized products, workers and services. Toffler (1980) has identified

that the number of workers doing identical work will decrease as the variety of occupations increase. Rehabilitation is not immune to this paradigm; and, as a result, many specialists are strengthening their roles within the rehabilitation process.

Rehabilitation counselors may find that their role in case management is strengthened; but at the same time, their responsibility for direct service delivery is lessened. To assume that counselors have the reponsibility in serving persons with disabilities seems to ignore the needs of specialized markets that require competencies beyond those received in rehabilitation counselor training.

The improvement of rehabilitation effectiveness and efficiency depends on the ability of rehabilitation administrators to be externally oriented. If agencies can respond to the splintering markets, the country will be strengthened as the skills, talents, and abilities of both rehabilitation professionals and persons with disabilities are more fully realized.



Chapter
Four

Management for the Future: A Priority

Historically, in times of stress, VR has responded in a reactive manner. It is now time to become proactive—and marketing is one vehicle which can be used. You can sense the beginning of this transition as agencies begin to seek out information, training, and technical assistance in marketing.

Spann, 1982

Objective

To provide a basis for efficient management strategies which will ensure the continued provision of quality rehabilitation services in a rapidly changing social and economic environment.

Summary

Management strategies are becoming increasingly important in vocational rehabilitation as a result of policies and action which link it with other program components, resources, practitioners, and service providers. This chapter discusses the application of the multidisciplinary approach at both the macro and micro level as a means for achieving greater efficiency. Managers and administrators within the state-federal program need to adopt and/or expand strategies and practices which include intimate contact with the various markets for the products and services of the rehabilitation program to achieve greater success.

Discussion

Management Concepts and Strategies

Vocational rehabilitation management practices in the future will be based on the following environmental realities:

1. Customer satisfaction is paramount. If the customer/consumer is not satisfied with the product or service delivered, they will seek an alternative source of supply. The customer/consumer may be the traditional rehabilitation client, an employer, taxpayer, or legislator. The notion that the customer is always right which has influenced the thinking of every successful business will have to permeate the thinking of rehabilitation administrators, if the program is to expand.

2. There is a need for a program designed from a professional's point of view based on existing markets and continuous market assessments. Professionals will increasingly focus their energies on developing the tools, products, processes, and services necessary to meet these market needs. Today brings us closer to where we want to be tomorrow. Peters (1982), author of In Search of Excellence, states, "a sample summary of what our research uncovered on the customer attribute is this: that excellent companies really are close to their customers. That's it. Other companies talk about it. The excellent companies do it."

   The particular relevance for marketing in terms of rehabilitation is clearly described in the following information excerpted from the report by the Ninth Institute on Rehabilitation Issues (1982).

The idea of marketing applied to the state-federal VR program is one of the hottest topics today. The beginnings of marketing activities are emerging in some agencies, and considerable interest in exploring marketing as a management function is evidenced by a number of states. Although individual marketing activities have been carried out for a long time by VR, only recently has recognition been given to the importance of positioning the marketing function within the agency and of its integration into both short- and long-term planning. Marketing has the potential for such significant program impact that it must be dealt with on the highest program level.

There are good and compelling reasons VR management must carve the time and manpower out of a shrinking organization and seriously study a marketing approach to the agency's management strategies. If you could step back and look objectively at both the macro and micro environments in which the agency is now operating, you would see the reluctance of the funding system to respond to needs...the tough competition from other rehabilitation systems...the increasing demands for services from handicapped individuals...the uncertainty as to whether the agency will be part of a state-federal program, or a state block grant program, or exist at all. Add to these the pressures in-house from employees who perceive themselves impotent to impact upon any of these external forces.

3. New markets are constantly sought or created.

4. There will have to be increasing flexibility in rehabilitation's approach to providing service, as well as increased experimentation with the types and ways of delivering services. This emphasis will probably take the form of action rather than research, because of funding limitations.

5. Programs designed to improve people productivity will have to be pursued by program managers and administrators. Greater involvement of people in the decisions that affect their work, as well as incentive for outstanding performance would do much to increase human productivity in rehabilitation. Ways and means must be discovered to overcome an inherent dilemma in the state-federal program; that is, a lack of monetary, professional, and other types of rewards for meritorious service.

6. Cost-cutting and loss reduction practices must be adopted by all rehabilitation managers and staff. Incentives to reward managers and staff who are able to cut costs or manage loss while maintaining service quality and achieving program outcome must be created throughout rehabilitation. There is much to be learned in the state-federal program from practices occurring in some private sector corporations.

There are many other programmatic options which, if pursued by agency managers and administrators, can have positive implications for service delivery, staff performances, and program outcome.

Implications for Service Delivery

The emphasis of this document is the multidisciplinary applications which will improve professional practice and increase the effectiveness of service delivery. The context in which each application occurs is exceedingly important. It does not require a great conceptual leap to conclude that staff performance and service delivery can be facilitated best in programs which involve intimate relationships with customer markets, networking of interagency resources, information records, service, and staff.

Program Management

Program managers have a major responsibility in constructing interagency programs based on networking principles. Provided these principles are used effectively, time delays in completing client assessments, developing and implementing rehabilitation plans, and achieving rehabilitation outcome can be reduced. Additionally, the reduction of waste by avoiding the duplication of information through timely exchange of existing data between team members can result in increased quality of decision-making and service delivery. The collaboration between staff that can be achieved through well conceived and properly implemented interagency agreements, can also promote creativity and improve the quality of the rehabilitation outcome.

. It may not be necessary for individual members of a multidisciplinary team to meet physically as a group. The use of modern technology needs to be investigated to ensure that distance does not inhibit the "mental" meeting of the team. Video conferencing, telephone conferences, electronic mail, and "Fax" copiers are but a few of the technological advances that enhance the "mental" meeting of the team.

Counselor Management, and Professional Practices

Teamwork, while producing a product greater than some of its parts, is nonetheless affected by the quality of each of its parts. Theories of synergy and systems are founded on this principle. Consequently, the rehabilitation counselor can improve multidisciplinary team function through personal management practices and applications of professional knowledge and skill, which promote timely and appropriate responses to the team's needs. Effective use of client and family resources of either a fiscal or personal nature can also promote improved performance of the counselor and the team.

Chapter
Five

The Counselor's Role in the Multidisciplinary Approach

...counseling is concerned with changing behavior by providing a situation in which the client who desires to change can become more responsible, more independent, more in control of himself and his behavior.

Sussman & Stewart, 1971

Objective

To explore the counselor function and responsibility in the multidisciplinary approach to rehabilitation.

Summary

In a broad sense, the primary goal of Vocational Rehabilitation is to bring individuals with physical and/or mental disabilities to the level of functioning necessary to be successful in the world of work. The rehabilitation counselor is the professional who serves as the link between client and services.

One of the most valuable functions performed by the Vocational Rehabilitation counselor is coordinating client service from a variety of available resources depending on client needs. The effective use of these available resources by the counselor requires both time-management skills and knowledge of support services within the community.

Discussion

State rehabilitation agencies differ in their priorities as to whom they will serve and which services will be provided. Further, most states differ in in such areas as: (1) how rehabilitation statuses are used; (2) terminology; (3) use of facilities; (4) caseload budget methods; and (5) criteria for good casework/case managers. Despite these differences, the basic elements that go into an effective multidisciplinary approach to rehabilitation by the counselor are generic in nature and can be used within any state.

The rehabilitation counselor performs many duties including the following:

1. Promotes case findings, receives and screens referrals, conducts interviews, and gathers information to determine eligibility and prognosis for vocational rehabilitation.

2. Screens, analyzes, interprets and evaluates medical, psychological, social, educational, and employment information regarding applicants.

3. Arranges for or administers psychological tests to ascertain client's mental level, aptitudes, interests, abilities and personal adjustment.

4. Plans with clients regarding physical restoration, training, and other services necessary to the attainment of realistic vocational goals.

5. Arranges and approves IWRP with clients with disabilities.

6. Promotes and coordinates the assistance and services of other agencies and community organizations.

7. Fosters independence and self-reliance in clients, and continually evaluates progress during the rehabilitation process.

8. Prepares rehabilitation plans, maintains necessary rehabilitation records and makes appropriate reports, including authorizations for expenditures for diagnostic purposes.

9. Assumes responsibility for suitable placement and follow-up in employment.

10. Reports to referral sources concerning the disposition of referrals.

To successfully perform all of these requirements, the rehabilitation counselor must possess the following skills, knowledge, and abilities:

1. Knowledge of social, psychological and physical aspects of disability.

2. Knowledge of counseling and guidance techniques.

3. Knowledge of occupations in terms of skills required, physical demands, training requirements and working conditions.

4. Knowledge and understanding of human behavior as related to personal, social and vocational adjustment.

5. General knowledge concerning medical information, the therapies, prosthetics, orthotics, and other services designed to remove or ameliorate the effects of disability.

6. Knowledge and understanding of community resources and conditions under which services are made available to applicants.

7. Knowledge of methods and techniques of individual case study, recording, and evaluation.

8. Ability to maintain satisfactory relationships with other agencies concerned with the problems of persons with disabilities.

9. Ability to work independently and with relatively little supervision.

The role of the rehabilitation counselor is comprehensive and varied. For counselors to be effective managers of a multidisciplinary team, they must first be effective time managers of their entire caseloads. Caseload management can be expedited and made more effective through the use of basic techniques during any status of the rehabilitation process.

The counselor's role as an effective team manager varies according to individual client needs; however, the counselor remains responsible for collecting, synthesizing, and coordinating the decision-making process. This professional does not make every medical or vocational decision, but coordinates and directs the necessary services toward the achievement of specific

objectives and the vocational goal. It is critical for the counselor to have relevant information about various disability groups. This should include information concerning a specific disability, the individual client, counselor observations, resulting functional limitations, observations of other professionals, and available resources.

The counselor uses the multidisciplinary approach to optimize the vocational rehabilitation process. Effective team composition depends primarily on the professional resources necessary to assist the client in achieving vocational rehabilitation goals and objectives. The composition of the team is dictated by the needs of the clients. The team may include members from various disciplines or simply the counselor and the client. It is the counselor's responsibility to involve the client in the rehabilitation process including active participation in the development of an IWRP and the resources necessary to meet the needs of the client.

The Client's Relationship to the Team

Unfortunately, there is a great deal of difference between what the client's relationship is to the team as a whole and what it should be. Many times things are done to (or for) the client instead of with the client. Rehabilitation encourages independence, but at the same time may discourage questioning by the client. Services must revolve around the client and as a result the individual who is disabled should be at the center of services--such as the "hub of the wheel"--and the core of the team. In no way can the team function effectively active involvement of the client. Without the client's approval, acceptance, and/or cooperation, efforts by professionals most often fail because the individual's needs are not being met.

Counselor Perceived Barriers to the Multidisciplinary Approach

Barriers to the multidisciplinary approach in vocational rehabilitation include but are not limited to the following:

1. failure to include the client as a member of the team in the decision-making process;

2. turf protection by team professionals;

3. inability of professionals to translate services to client needs;

4. logistics of team meetings;

5. intimidation of team members;

6. passivity of team members;

7. inadequate knowledge/skills of team members.

Client Benefits of the Multidisciplinary Approach

The three principal benefits of the multidisciplinary approach that make it more effective than other processes are:

1. The multidisciplinary approach allows clients to participate in a goal-oriented comprehensive interdisciplinary and coordinated rehabilitation process.

2. The multidisciplinary approach helps ensure that clients' rehabilitation plans will be individually tailored and coordinated.

3. Clients are involved in the planning and implementation of their own individual programs.

Within the realm of these three major areas, it is mandatory that good communication avenues be provided to all concerned parties. The client must have a voice in program planning and be provided with a formal support system. Also, in order for clients to feel like deserving total individuals rather than just persons with disabilities, formal referrals must be made on their behalf to other available resources.

Barriers to the Multidisciplinary Approach

Deficits in the multidisciplinary approach occur when the counselor fails to take responsibility as an effective team manager. The state rehabilitation counselor must create a team for each individual client. Many times, if not managed appropriately, clients and/or their guardians can be intimidated by the group process. Passive, domineering, or unprepared team members can inhibit the overall team process, as can personality conflicts and biases among team members. Unless there is good communication between all team members, benefits are lost through misunderstandings and mixed messages that go into the ultimate decisions regarding the client's future. The rehabilitation counselor must ensure that communication between all team members is timely, ongoing, and focused on the client's progress toward a vocational goal.

Chapter
Six

Impacting Service Delivery

Model your thoughts and actions after men and women who have been creative in their service to others.

Waitley, 1984

Objective

To identify available resources and strategies that facilitate service delivery to persons with disabilities through the multidisciplinary approach.

Summary

A world beset by change in the social, economic, technological and political areas all have significant implications now and in the future for persons with disabilities. If rehabilitation agencies are to be prepared for these challenges, the past and present must be understood in terms of provisions and outcomes of services. The use of innovative methods or traditional techniques should employ the delivery of services in a personal, efficient and effective manner. The multidisciplinary approach to rehabilitation can be expanded to encompass more than medical and rehabilitation professional disciplines. This expansion may include the use of computer technology, office automation, specialized counselor training, and alternatives to the traditional work site.

Discussion

Multidisciplinary Approach

Traditionally, vocational rehabilitation has considered the multidisciplinary approach to be a team of experts from various fields all working toward the most suitable vocational rehabilitation of the client. This is a valid concept that should be implemented more often by other agencies and organizations. The multidisciplinary approach is becoming necessaary to serve an increasing client population with decreasing funds and resources.

Technology and Systems Development

The need for increased effectiveness of rehabilitation in serving its various markets must include the application of all levels of technology. Cutbacks in fiscal and personnel resources require that rehabilitation administrators allocate resources in such a fashion that immediate goals and objectives can be met. Provisions must be made by administrators for future growth of rehabilitation agencies through proper planning and production.

As with most service agencies, rehabilitation depends on the management of information. Information or data management can improve a rehabilitation administrator's ability to make decisions and to respond to the needs of consumers. A comprehensive Management Information System (MIS) utilizing computers can aid a rehabilitation agency in:

* client services;
* employer services;
* indirect and support services;
* management;
* vendors and facilities; and
* personnel (VR-TECH, 1982).

Micro-computer technology has not generally been associated with the provision of rehabilitation services; however, the future of VR effectiveness may depend on it. Most rehabilitation administrators have little training or experience in micro-computer technology. Management Information Systems are complex and require insights not usually possessed by individuals trained in rehabilitation. Rehabilitation will need to open the profession to outsiders to obtain recommendations on how a Management Information System can be developed. According to Robert Townsend, (1978) author of Further Up the Organization, Systems are like roads...very expensive...and no good building them until you know exactly where they're going to wind up.

The following synopses of innovative programs are presented for the benefits of administrators and/or front line managers interested in facilitating the delivery of rehabilitation services.

Rehabilitation Initial Diagnosis and Assessment for Clients (RIDAC)

This research and demonstration project started in 1975 with the explicit goal of providing multidisciplinary services to expedite the rehabilitation process. This unit, housed in a local rehabilitation field office in Little Rock, Arkansas, provided four basic services: General medical examinations; psychiatric evaluations; psychological evaluations and vocational evaluations. During the three-year duration of the project, RIDAC served a total of 2,108 clients. This project proved that services to clients could be expedited by reducing the time spent in referral status by several months. The close proximity of the field counselor to the RIDAC staff was another significant benefit. Although RIDAC's initial research and demonstration funding ended in June, 1978 the project was integrated into the regular Arkansas rehabilitation program. Services provided by RIDAC have proven to be very cost-effective. RIDAC's purpose continues to be that of to providing assistance and direction to counselors by expediting the screening and assessment of clients. The project has shown that the multidisciplinary approach has substantial benefits for both clients and rehabilitation professionals.

RIDAC facilitates the screening of clients needing extended evaluation, for immediate acceptance into a rehabilitation program, or for declaring them ineligible for services before investing a lot of client and staff time. The RIDAC project continues to be successful in reducing time lag, the number of cases closed from referral status, and in increasing the number of cases accepted for services. (Rehab Brief, 1979). For more information contact:

Arkansas Department of Human Services
Division of Rehabilitation Services
Little Rock, AR 72201

Mobile Rehabilitation Engineering Unit

This unit is a self-contained fabrication laboratory operated by the Virginia Department of Rehabilitation Services. It is equipped with metal working, woodworking, welding, electronics, etc., and complete staff quarters.

The Woodrow Rehabilitation Center staffs a tractor-trailer rig and sends it where the clients are to be evaluated for rehabilitation aids. For more information contact:

Mobile Rehabilitation Engineering Unit
Woodrow Wilson Rehabilitation Center
Fisherville, VA 22939

Office Automation

Automation of routine office tasks has as its goal the increased levels of production, decreased errors, and provisions for continuity of systems among similar offices. Accomplishment is often arrived at in four phases: introduction (clerical applications), expansion (professional applications), integration (ties to outside data sources and document transfers), and maturity (of the users). Office automation's selling point has been raising productivity levels (Computer Decision, 1985). For more information, contact any major office supply and computer center.

Computer Technology Applications for Persons with Disabilities

The Trace Center at the University of Wisconsin is one of the leaders in adapting computers to fit the needs of persons with disabilities. Their devotion to computer applications allows for a full awareness of state-of-the-art applications developed by others. Thus, they can serve as an invaluable referral/resource agent. If a particular device is available, the Trace professionals will be aware of it. and can provide information as to where it can be obtained.

Areas of involvement by Trace include:

* the development and/or registration of software enabling more efficient use of hardware units;

* the development of alternate input components that facilitate ease of access by persons with limited physical capabilities;

* adaptations to computers to control other needed functions, such as augmentative communication or environmental control.

The generalized applications for adapted computers are limitless and may include:

* augmentative communication; environmental control;
* physical rehabilitation/restoration via computer as a rehabilitation modality;
* cognitive retraining applications;
* enhancement of vocational evaluation modalities;
* vocational placement, using computers as an assist to job performance;
* educational assistance.

These brief applications utilize the computer unit as a tool for the person with a disability.

Computers also have many advantages when used in the rehabilitation program. Here, a multitude of applications emerge. Examples include:

* Objective Evaluation of Driving Capabilities (Louisiana Tech Biomedical Engineering Division);
* Program Evaluation tool in determining a program's effectiveness;
* data processing and manipulation;
* CAD/CAM in Vocational Training (Drafting Department, Woodrow Wilson Rehabilitation Center);
* database accessing and development (Vocational Rehabilitation Department, Iowa).

The fact that computer technology and applications have come of age is a reality. To be sure, they have a role in rehabilitation. For more information contact:

Trace R & D Center, University of Wisconsin
1500 Highland Avenue
Madison, Wisconsin 53794
(608) 262-6966

Computer Assisted Rehabilitation Services

The use of quality systems in rehabilitation can provide counselors with professional and rehabilitation knowledge that would take years to acquire first hand. These systems will assure a quality services to clients in the future. The rehabilitation counselor should become a sophisticated user of computer technology. A variety of applications are planned by the Texas Rehabilitation Commission in its Texas Casework Model.

Four modules are represented:

* Utilities Module (Forms generator, calendaring, policy prompter, similar benefits screening, provider listings, etc.),

* Expert Information Module (Disability and service information of a comprehensive nature),

* Feasibility Determination Module (Comparison of client data to others of like characteristic with outcomes),

* Planning and Placement Module (Career guidance, occupational information job seeking skills, placement plan, etc.) (Chan, et. al., 1985).

Rehabilitation Engineering Service (RES)

Rehabilitation Engineering is the application of engineering technology to enhance the rehabilitation process. Broadly speaking, the profession is divided into the two categories--research and service delivery.

An RES is a technical support program to each of the rehabilitation disciplines which can be used to overcome either client-specific or program-specific problems. RES can provide valuable support from the onset of rehabilitation (in the acute medical stage) through the final stages of rehabilitation (vocational placement, independent living).

Examples of RES support include the following:

- RES provides information regarding all types of technical equipment or tools available to rehabilitation and can be considered the technical liaison to rehabilitation. The rehabilitation engineer maintains an extensive library of both commercial adaptive equipment and specially-designed, one-time items developed by colleagues.

- Consultant and/or implementor of the technical systems that facilitate accessibility and, more importantly, independence in accessibility.

- Implementor, an adaptor of commercial equipment such as wheelchair, postinal support inserts, augmentative communication tools, self help aids, medical and vocational special equipment.

- Custom designer/fabricator of specialty equipment specially fit to the client and used to overcome barriers identified by the rehabilitation team. Examples include: modifying work areas for access to the total job by persons with disabilities; custom-designing home environments for independent and safe living; interfacing equipment for ease of utilization; special design of self help aids enabling independence in daily living tasks; and more.

- Support to programs, such as occupational, physical, recreational therapies, speech and hearing, Head Trauma Specialists, Vocational Evaluation, etc. by implementing the above support mechanisms on a programmatic basis.

Every state does not have an RES in operation, however, these programs are becoming more numerous. As RES programs develop nationally, more and more exemplary services develop.

The following descriptions of several RES programs are listed to acquaint the reader with their programs and services.

- RES, North Carolina VR - Concerned primarily with building and home accessibility, and driving independence. Removing the technical headaches from the counselor, they consult, recommend equipment, draft and review bids, and follow-up the implemented equipment.

- RES, Virginia DRS - Conducts a broad service spectrum from accessibility evaluations to custom development of specific adaptive aids. Two facilities house comprehensive fabrication laboratories for the custom fabrication processes. The Virginia program emphasizes the implementation of special equipment for medical, pre-vocational, vocational training, and minimizing vocational placement barriers. Enormous success has been realized through the cost-effective adaptation to worksites which facilitates competitive employment for workers with disabilities.

- Smith-Kettlewell Visual Sciences, San Francisco, CA - One of the leaders in development of specialty equipment for those with visual or hearing deficits. From "talking tools" to visual or vibratory communication alert systems.

- The Cerebral Palsy Research Foundation of Kansas, Inc. - In addition to providing invaluable support to vocational placement, this entity is one of the strongest lobbying voices for increased recognition and support of RES.

Others include: RES, Matheny School, Peapack, NJ (service emphasis to educational support for children and adolescents); RES, University of TN, Memphis, TN (leaders in seating research and services); RES, University of Michigan Medical Center (both a medical center-based and university based program). Certainly, many other outstanding programs exist. For more information, contact:

Rehabilitation Engineering Society of North America
Suite 700, 1101 Connecticut Avenue, NW
Washington, DC 20036

Telecommuting

The State of California, Department of General Services, plans a two-year project to test the concept of "telecommuting." Telecommuting is defined as the total or partial substituting of computers and/or communications technologies for the commuters. Telecommuting has become more desirable in the past decade as the number of information workers has increased and as computer and telecommunication technologies have continued their spectacular advance. (Jala Associates, 1985).

Alternative Work Environments

The cost of office space is a major factor in the containment of administrative costs. One way to meet the challenge of cost containment is by developing alternative work environments. The Texas Rehabilitation Commission has implemented a program which examines the work roles of its counselors, their personal characteristics and skills, and available resources in an effort to select specific counselors and offices which may benefit from alernative work environments. In this concept, the worker maintains a base of operations in the home. All equipment is provided by TRC, but no clients are seen in the home/office setting. Arrangements are made to use community facilities for client meetings. In effect the program is really a community based service program. Current technology is used to ensure that communication doesn't suffer. Electronic mail, portable telephones, and pagers make the counselor more accessible than in the usual walled office environment.

The concept of a "remote" counselor requires a change in management practices as well as in the evaluation of counselor performance. It does not allow for direct observation and adherence to a normal work day/work week. Instead, management and evaluation are based upon performance and results. The Michigan Rehabilitation Services also has a number of staff working in alternative work environments.

Use of Electronic Databases

JAN (Job Accommodation Network) is operated out of West Virginia University. Employers are urged to call JAN and discuss their concerns about meeting the needs of their disabled employees. The database is used by the operators to access information on technological breakthroughs which assist disabled workers in performing specific tasks.

The unique aspect of JAN is the human touch. Individual discussions with the operators allow for a broader knowledge base from which to assist employers with disabilities. JAN has four basic functions: providing awareness of job accommodations, finding information that fits a specific need, determining the cost of needed accommodations, encouraging employers to provide valid employment opportunity for persons with disabilities.

ABLEDATA...a medical/rehabilitation database, is a cataloging system for commercial adaptive aids and manufacturers of rehabilitation devices. Informational categories include Personal Care, Vocational/Education, Seating, Mobility Therapeutic Aids, Sensory Assistance, etc. ABLEDATA can be valuable for those in need of rehabilitation products for their programs or clients.

Contact ABLEDATA at:

The ABLEDATA System - National Rehabilitation Center
4407 Eighth Street, NE
Washington, DC 20017

Computer Assisted Career Exploration/Guidance

Career exploration, involving materials and activities designed to help individuals understand the world of work in relation to their abilities, needs, interests, aptitudes, and values, is a vital component of the rehabilitation process (Sampson, et. al., 1985). Many resources are available for use by rehabilitation counselors in vocational planning with clients. In today's production oriented world, including rehabilitation, many counselors do not have time for the traditional vocational assessment and career exploration. The result is that client vocational objectives are all too often based on the client's stated desire and a quick screening of other circumstances to eliminate obvious job/client mismatches.

Computer assisted vocational guidance systems have made the job of vocational assessment quicker, easier, and more comprehensive. These systems permit the quick manipulation of variables in dealing with occupational exploration, transferable work skills, job analysis, placement, and other realistic problems in vocational counseling and vocational rehabilitation. (Botterbusch, 1983). There are far too many systems to discuss in a publication of this type, however. Information about these and other systems are available through:

Association of Computer-Based Systems for Career
Information (ACSCI) Clearinghouse
University of Oregon
1787 Agate Street
Eugene, Oregon 97403

Special Emphasis On Skills Training to Improve the Effectiveness of Services

The range of services available too often makes it possible for clients to benefit from training in given areas. One area which counselors and clients can derive benefit is the job placement. As a result of the need for this service, a placement training package was developed and implemented by the Texas Rehabilitation Commission. The purpose of this package was to provide a systematic process to improve the placement rate as well as ensure longer term placement. Job Placement Success for Counselors and Clients is a package which incorporates the latest techniques in job development and placement of persons with disabilities, borrowing from business and industry the concept of "marketing" the program, services, and disabled job applicants. The program allows the counselor to develop a placement strategy in which he/she is most comfortable. A variety of materials is presented for the counselors' use to assist them in placement activities. One unique feature of the package is the use of inter-active video systems which allow the client and counselor to model good job placement techniques, e.g., interviewing skills. The program itself focuses attention on preparing the client for the interview and the counselor for an effective presentation to employers.

In-service training on certain aspects of other program areas often proves beneficial in the provision of services. A good example is awareness training of programs related to providing services to rehabilitation clients and/or those receiving social security benefits. The Social Security Administration, in conjunction with the Council of State Administrators in Rehabilitation (CSAUR), has prepared a guide explaining various "work incentives for the disabled and blind." This publication (SSA Pub. No. 64-015) is available through SSA regional offices.

Chapter
Seven

Improving Rehabilitation Programs Through Networking

...people talking to each other, sharing ideas, information, and resources. The point is often made that networking is a verb, not a noun. The important part is not the network, the finished product, but the process of getting there — the communication that creates linkages between people and clusters of people.

Naisbitt, 1982

Objectives

To emphasize the importance of the multidisciplinary approach for rehabilitation professionals.

To highlight ways in which networking can improve case management.

To encourage counselors and administrators to become more "team conscious" in solving problems and reaching goals.

Summary

This chapter discusses how the multidisciplinary approach can best be implemented at the management, counselor and service delivery levels. This material should prove useful for the in-service training of existing staff, as well as in the growth and development of new practitioners in the field of rehabilitation.

Discussion

At a time when all human service programs are faced with diminishing resources to serve an ever-increasing population of people with disabling conditions, it is critical that all agencies work in harmony. Once the various agencies coordinate efforts to achieve mutual goals and overcome common problems, agency-imposed, "professional" barriers will be resolved. Too, resources will be conserved when responsibilities for serving rehabilitation clients are shared. This will result in services to an increasing number of individuals who are severely disabled. Without question, future rehabilitation clients will be those who need multidisciplinary services. With the implementation of the multidisciplinary approach on a wider scale, it can be anticipated that the roles and responsibilities of rehabilitation counselors will change as well as the program itself.

Types of Multidisciplinary Approaches

Dahms (1980), reporting on the function of the multidisciplinary approach, identified three variants of this approach: assessment, consultation teams and long-term coordination teams.

The following is a synopsis of the research findings.

I. CHARACTERISTICS VIEWED AS MOST IMPORTANT IN THE ASSESSMENT TEAM MODEL

A. Structural Characteristics

1. Multidisciplinary composition
2. Members with expertise in assessment and diagnosis

B. Process (During Meeting)

1. All relevant information exchanged within legal limits
2. Discussion of needed additional information and plans to obtain
3. Family-focused perspective with attention to needs of all family members and environmental factors

Products of Meeting

Identification of person responsible for follow-up

C. Outcome

1. Outcomes Related to Clients

a. Accuracy in assessment and diagnosis
b. Communication of one consistent treatment plan to client/family

2. Outcomes Related to Clients

a. Commitment by agencies to maintain multidisciplinary process for cases
b. Increase in number of referrals from professionals
c. Improvement in identification, assessment and diagnostic skills of clinical workers

II. CHARACTERISTICS VIEWED AS MOST IMPORTANT IN THE CONSULTATION TEAM MODEL

A. Structural Characteristics

1. Multidisciplinary composition
2. Members with expertise in assessment and treatment

B. Process (During Meeting)

1. All relevant information presented to team by referring person within legal limits
2. Client-focused perspective with attention to needs of all family members and environmental factors

C. Outcome

1. Outcomes Related to Clients

Communication of one consistent treatment plan to client/family

2. Outcomes Related to Service Delivery

a. Appropriate and extensive use of community resources
b. Reduction in duplication and/or gaps in needed services
c. Commitment by agencies to maintain multidisciplinary process for clients
d. Improvement in morale of team staff

III. CHARACTERISTICS VIEWED AS MOST IMPORTANT IN THE LONG-TERM COORDINATION MODEL

A. Structural Characteristics

1. Multidisciplinary composition
2. Members with expertise in assessment and treatment

B. Process (During Meeting)

1. All relevant information presented to team by referring person
2. Client-focused perspective with attention to needs of all family members and environmental factors

Products of Meeting

a. Comprehensive review of family situation
b. Comprehensive, integrated treatment plan addressing needs of family unit and individual family members

C. Outcome

1. Outcomes Related to Clients

a. Reduction in duplication and/or gaps of service for client/family
b. Communication of one consistent treatment plan to client/family

2. Outcomes Related to Service Delivery

a. More appropriate and extensive use of community resources
b. Reduction in duplication and/or gaps in needed services
c. Commitment by agencies to maintain multidisciplinary process for client cases
d. More frequent inter-agency communication about treatment plans and progress of cases

Implication for VR

Backer (1985) in an article, "Networking in Rehabilitation", identified networking as an "informal, but systematic, process by which people communicate, and share ideas and resources in order to solve common problems or reach mutual goals."

Backer further outlined these challenges and pointed out that networking is a natural process in rehabilitation. He outlined these challenges as follows:

(1) rehabilitation is a multidisciplinary field with medicine, psychology, occupational therapy, physical therapy, nursing and a number of other professions having parts to play.

(2) the bureaucracy inherent to most rehabilitation organizations makes effective networking difficult, as is true for all human service fields (Sarason & Lorentz, 1979). While formal networks exist in bureaucratic organizations, they are often limited by cumbersome procedures, traditions, and the need to observe protocol in potentially political situations. Consequently, most good networks exist on the fringes of--but do not necessarily exclude--formal organizations.

(3) effective networking is needed by consumer groups, because the consumer movement in rehabilitation is still fairly new, and does not have established structures such as those of the State-Federal VR system. To become integrated with rehabilitation service providers, and to communicate better among themselves, consumers, their families, and people in the community concerned with disability need the advantages of networking.

(4) networking is essential at the present time because of limited resources available to serve clients and maintain service organizations. When money is scarce, networking can help solve problems in informal ways, arrange joint ventures that prevent costly duplication, locate free or in-kind resources, and facilitate joint political action to stem further cutbacks in essential areas. (To further illustrate Backer's Fourth point a "Model" agreement between a public funded agency and a church related facility is shown in Appendix F.

(5) the information explosion in rehabilitation often makes it difficult to find the right solution to a given problem due to the abundance of non-relevant information. The National Rehabilitation Information Center alone has more than 50,000 documents in its collection that are related to recent developments in rehabilitation. Even more information is available through word-of-mouth or informally printed materials. Networking provides a focused access to information and enriches what can be learned from someone else who has considered or implemented a given innovation.

Coordination of services is crucial for the consumer and for the survival of the agencies involved. Networking will result in rehabilitation agencies being able to serve additional clients. In essence, this is networking at its finest.

References

References

Backer, T. E., (Oct./Nov./Dec., 1985). Networking in rehabilitation. Journal of Rehabilitation.

Berkowitz, E. (1984). Social influences on rehabilitation planning: Introductory remarks. Report on the Ninth Mary E. Switzer Memorial Seminar. L. G. Pearlman and G. F. Austin, Eds., National Rehabilitation Association.

Botterbusch, K. (1983). Comparison of computerized job matching systems. Materials Development Center, University of Wisconsin-Stout: Menominee, Wisconsin.

Burns, J. M. (1978). Leadership. New York: Harper Colophon Books.

Chan, F., McCollum, P., & Pool, D. (1985). Computer assisted rehabilitation services: A preliminary draft of the Texas Casework Model. Rehabilitation Counseling Bulletin, 28(4), 219.

Conn, G. A. (1983). Rehabilitation placement - The federal rehabilitation administrator's perspective. The Professional Supplement, The Job Placement Division, 11-13.

Conn, G. A. (1986). Caseload trends in the state-federal rehabilitation program through fiscal year 1985. American Rehabilitation, 12(2), 2-5.

Corthell, D. W., et. al., (1984). Continuum of services: School to work. Menomonie, Wisconsin: Stout Vocational Rehabilitation Institute, University of Wisconsin-Stout.

Dahms, Kinney, Vanek. (1980). Report on the multidisciplinary team evaluation project. Pub Michigan Evaluation Resources Center: Ann Arbor.

Dietl, D. (1985). JAN and job: A single thread. Journal of Rehabilitation, 52(2), 11. National Rehabilitation Association: Washington, DC.

Eighth Institute on Rehabilitation Issues. (1981). Delivery of rehabilitation services to inner city non-whites. University of Wisconsin-Stout SVRI: Menomonie, Wisconsin.

Elder, J. K. (1984). Access to employment. Iowa Protection and Advocacy Division, Keynote Address in Des Moines, Iowa.

Emener, W. G. (1986). Futuristic perspectives and recommendations for the National Rehabilitation Association. Journal of Rehabilitation (Special Issue, Summer).

Emener, W., & Smits, S. (1980). Insufficient/ineffective counselor involvement in job placement activities: A system failure. Journal of Rehabilitation Administration, 4, 147-154.

Griswold, P. (1983). Rehabilitation placement - The state vocational rehabilitation administrator's perspective. The Professional Supplement, The Job Placement Division, 11-13.

Hawley, Grant, Haqq, Jiang, & Montesinos. (1983). The marketing adult in rehabilitation: A model. Journal of Rehabilitation Administration, 7(4), 131-138.

Health, Education and Welfare Audit Agency. (1978). Review of the administration of the vocational rehabilitation program in five states. Washington, D.C.: Office of the Inspector General, (No. 15-80300).

Human Resources Center. Programmatic research on employment preparation for the handicapped. Final report submitted to the National Institute of Handicapped Research.

Hunt, J. (1969). A decade of progress. The Journal of Rehabilitation, 35(1), 9-12.

Jala Associates, (1985). "Telecommuting: A Pilot Project Plan for the Department of General Services, State of California." Los Angeles.

Javits, J. (1970). Government and rehabilitation agencies: A creative partnership. The Journal of Rehabilitation, 36(2), 10-16.

McConnell, L. R. (1984). A response to the "Changing perception of disability and the future of rehabilitation" by Harlan Haan. Social Influences in Rehabilitation Planning: Blueprint for the 21st Century. Ninth Mary E. Switzer Memorial Seminar, Alexandria, VA. National Rehabilitation Association.

Nadolsky, J. (1986). Ethical issues in the transition from public to private rehabilitation. The Journal of Rehabilitation, 52(1), 6-8.

Naisbett, J. (1982). Megatrends. New York: Warner Books.

National Council on the Handicapped. (1968). Toward independence: An assessment of federal laws and problems affecting persons with disabilities - with legislative recommendations. Library of Congress, Catalog Number 85-082605. ISBN 0-936825-00-6.

Pati, G. C. (1983). Industry and rehabilitation: A private-public partnership in utilizing the disabled. The Professional Supplement, The Job Placement Division, 21-31.

Peters, T. (1986, March 17). A different drummer for U.S. firms. U.S. News and World Report, 48.

Peters, T. J., & Waterman, R. H. (1982). In search of excellence: Lessons from America's best run companies. New York: Harper & Row, Publishers.

Rehab Brief, 2(1), (1979). Washington, DC, Rehabilitation Services Administration.

Rehabilitation Act of 1973 (PL#93-112) 93rd Congress.

Sampson, J., McMahon, B., & Burkhead, J. (1985). Using computers for career exploration and decision making in vocational rehabilitation. Rehabilitation Counseling Bulletin, 28(4), 242.

Selznick, P. (1957). The inbuilding of purpose. Leadership in Administration: A Sociological Interpretation, New York: Harper & Row.

Shawhan, C. (1984). In-Service Program to the Rehabilitation Education and Services Branch, Iowa Department of Public Instruction, Des Moines, Iowa. Rehabilitation Placement - Job Development/Job Placement Institute, Drake University.

Sinick, D. (1977). Vocational counseling trends in rehabilitation settings. Journal of Rehabilitation, 43(3), 19-21.

Smith-Fess Act of 1920 (Civilian Vocational Rehabilitation Act).

Soldier Rehabilitation Act of 1918.

Spann, G. (Ed.) (1982). Marketing a strategy to promote the rehabilitation of handicapped individuals. Ninth Institute on Rehabilitation Issues. Institute, West Virginia: West Virginia Rehabilitation Research and Training Center.

Spann, G. (1983). Developing a conceptual framework for marketing of vocational rehabilitation. Rehabilitation in the Public Mind: Strategies of Marketing. Seventh Mary E. Switzer Memorial Seminar, Alexandria, VA: National Rehabilitation Association.

Sussman, A. E., & Stewart, L. G. (1971). Counseling with deaf people. New York: Deafness Research and Training Center, New York University School of Education.

Switzer, M. E. (1967). Implementing new opportunities. The Journal of Rehabilitation, 33(1), 37-38.

The Vocational Rehabilitation Act Amendment of 1943 (PL#78-113) 78th Congress.

Toffler, A. (1980). The third wave. New York: Bantam Books with William Morrow and Company, Inc.

Tooman, M. (1983). Perspectives in placement. The Job Placement Division Digest, XV(2).

Waitley, D. (1983). Seeds of greatness. New York: Pocket Books Publishers.

Weicker, L. (1986, June). Weicker introduces senate version of rehabilitation act extension. Washington Update, Alexandria, VA: National Rehabilitation Association.

Wood, L. (1985). Computer Decisions, "OA Refined."

Wright, G. (1980). Total rehabilitation. Boston: Little, Brown & Company.

Appendices

APPENDIX A

Prime Study Group

B. Douglas Rice, Ed.D.
Sponsor
Arkansas Research and
Training Center in
Vocational Rehabilitation
P. O. Box 1358
Hot Springs, AR 7190

Bob Losin
Michigan Rehabilitation
Services
P. O. Box 30010
Lansing, MI 48909

Greg Solum
Missouri Division of
Rehabilitation
2401 East McCarty
Jefferson City, MO 65102

Jon Schuch
Division of Prosthetics
and Orthotics
University of Virginia
Medical Center, Box 467
Charlottesville, VA 22901

Marvin L. Tooman, Ed.D.
Rehabilitation Education
and Services Branch
510 East 12th Street
Des Moines, IW 50319

Robert Hope
Chairperson
Division of Rehabilitation
Services
1401 Brookwood Drive
P. O. Box 3781
Little Rock, AR 72203

Harold Thomas
RIDAC
708 West Second Street
Little Rock, AR 72201

Wayne Sanders
Texas Rehabilitation
Commission
118 E. Riverside Drive
Austin, TX 78704

William Garner
Rehabilitation Institute
Southern Illinois University
Carbondale, IL 62901

William (Doc) Williams
Division of Rehabilitation
Services
400 Deaderick Street
11th Floor
Nashville, TN 37219

Carol Cato
Division of Rehabilitation
Services
1401 Brookwood Drive
P. O. Box 3781
Little Rock, AR 72203

APPENDIX B

Total Study Group

Ann Cloyd
Counseling & Evaluation
Center for the Deaf
2400 W. Markham
P. O. Box 3811
Little Rock, AR 72205

Donald W. Dew
George Washington University
2300 Eye Street, NW Suite 714
Washington, DC 20037

Richard D. Faulkner
Division of Rehabilitation
Services
231-C South 10th Street
Griffin, GA 30223

Dorcas Hernandez-Arroyo
State Training Services Coordinator
Puerto Rico Vocational Rehabili-
tation Program
P. O. Box 1118
Hato Rey, Puerto Rico 00919

Harry B. Hiett
Rehabilitation Services
708 West 2nd Street
Little Rock, AR 72201

Ralph E. Jones
Rehabilitation Services
708 West 2nd Street
Little Rock, AR 72201

Neal Little, Ed.D.
Arkansas Research and
Training Center in
Vocational Rehabilitation
P. O. Box 1358
Hot Springs, AR 71902

Ron McGovern
Division of Vocational
Rehabilitation Services
2100 Atlantic Avenue
Atlantic City, NJ

Charles H. Merritt
Virginia Department of
Rehabilitation Services
4901 Fitzhugh Avenue
Richmond, VA 23230

Kay Mitchell
Counselor
708 West 2nd
Little Rock, AR 72203

Jerry Morrison
Illinois Department of
Rehabilitation Services
622 E. Washington Street
Springfield, IL 62705

Susan Philpott
Division of Rehabilitation Services
P. O. Box 3781
Little Rock, AR 72203

Nancy Quinn
Office for the Deaf and Hearing
Impaired
Division of Rehabilitation Services
1401 Brookwood Drive
Little Rock, AR 72205

Marvin S. Reed
Office of Vocational Rehabilitation
Room 230 State Office Building
333 East Washington Street
Syracuse, NY 13202

Melinda Wilson
Association Deputy Director
Department of Rehabilitation
8929 South Sepulveda
Los Angeles, CA 90045

APPENDIX C

Organizations Concerned with Policy Making and Program Development

National Council on the Handicapped

The National Council on the Handicapped, an independent federal agency comprised of 15 members appointed by the President, is designed to review legislation, programs, and policies of the federal government. It has recently completed a set of 18 policy recommendations on federal programs affecting the disabled, as well as making recommendations for statutory changes in federal laws and programs.

This review was also designed to determine the extent to which federal laws and programs "provide incentives or disincentives to the establishment of community-based services for handicapped individuals, promote the full integration of such individuals in the community, in schools and in the workplace, and contribute to the independence and dignity of such individuals." Their report to the President entitled, "Toward Independence" lists three general conclusions:

a. Approximately two-thirds of working age persons with disabilities do not receive social security or other public assistance income.

b. Federal disability programs reflect an overemphasis on income support and underemphasis of initiatives for equal opportunity, independence, prevention, and self-sufficiency.

c. More emphasis should be given to federal programs encouraging and assisting private sector efforts to promote opportunities in independence for individuals with disability.

In its report of the 45 major federal programs that focused on citizens with disabilities, the Council made several recommendations dealing with shifts in resources; reduction of barriers, both structural and attitudinal, as well as some program consolidation.

While the Council's efforts in terms of their review and recommendation are far reaching, their recommendations were based on input from a variety of sources. The impact of those recommendations on social policy has yet to be determined. Some would suggest that the Council expresses a particular point of view limited by its ties to the executive branch and hence reflects a conservative approach to policy. There is also the feeling that the composition of the Council is subject to change as administrations change. An additional limitation of the Council is that it lacks any effective oversight function as regards existing programs.

Council of State Administration of Vocational Rehabilitation

CSAVR has also demonstrated successful leadership in developing the issues and support for changing the State/Federal Rehabilitation Program through a series of legislative amendments. But while it has achieved success in ensuring that the State/Federal Program adapts to environmental demands, it has yet to tackle the problem of comprehensive national policy development which would in great measure resolve the problems identified in the National Council for the Handicapped Reports cited previously.

Congress as a Source of National Policy

In the effort to create a rational national policy of service for citizens with disability, some suggest that Congress, beset as it has been by an increasing number of specific interest groups on the one hand and a lack of broadly based counsel on the other, has had difficulty in recognizing and reconseling the conflict in policy and program resulting from its various legislative acts. For these reasons, Congress has not been able to play a major role in promulgating national policy on behalf of citizens with disabilities.

National Rehabilitation Association

In looking at NRA as a vehicle for policy and program change, we find that, in the view of some, NRA has done its finest work and earned its broadest constituent support when it has applied its resources to national policy and program issues; i.e., the amendments to the Federal Rehabilitation Act or in contesting the Florida Umbrella Agency. In the Florida Umbrella Agency case, the governor of the state was attempting to dissolve the State VR Program and assign its responsibilities to other human service programs and thereby weaken its impact and accountability for serving Florida citizens with disability. NRA, along with CSAVR and the Federal VR agency, were able to mount sufficient national pressure, resulting in successful litigation which prohibited the governor's effort to dissolve the state agency.

NRA is one organization currently structured to provide the national, state, and local perspectives that appear to be necessary to establish a national disability policy. It, some would suggest, is experiencing a dilemma of purpose and is involved in an internal debate to determine if it will continue to focus the majority of its energies on internal association issues (i.e. the number and role of professional divisions), or refocus its resources by asserting national leadership leading to the development of a comprehensive national policy for serving citizens with disabilities.

Emener (1986), in a manuscript dealing with the future of NRA, recommends that "...NRA broaden its concept of Rehabilitation and welcome the involvement of the variety of identifiably viable constituency groups." He points out that "...many Rehabilitation professionals feel that NRA has tended to put its head in the sand when it has come to the big issues..." and "...that NRA has spent too much time attending to the affairs of NRA..."

Emener also suggests a streamlined organizational structure for NRA involving three major components:

1. NRA (e.g., composed of its officers and elected and appointed officials);

2. Professional Divisions (e.g., NRCA, VEWAA); and

3. Interest Groups (CSAVR, NAIL).

While he does not speak to a revised way of conducting association business, shared decision power among the three elements of the organization would be essential. Professionals and consumers would have to have an equal stake in association business.

One potential way of ensuring the revitalization of NRA would be for it to commit itself to the development of a National Policy for citizens with disability as a primary objective of the assocation. In this way, NRA could attract the support necessary to broaden its political and talent base in order to exert both leadership and influence at the federal and state level. This commitment to the development of a National Policy would not preclude the legitimate business of the various divisions of NRA. It would merely, and very importantly, bind the divisions together in a shared purpose of greater importance to citizens with disability more than one that is devoted to the more parochial concerns of divisional constituencies. Division leadership would have a dual responsibility in this structure: that is, when dealing with national policy issues, they would forsake their divisional identities and pursuit of divisional concerns and lend their talent and support to the broader objective of national policy.

APPENDIX D

Marketing Audit for a Job Development and Placement Program

I. Mission of the Program

A. Is there a written mission statement for the program?
B. If so, does it identify the purpose, goals and objectives of the program?

II. Environments

A. Community Involvement

1. Demographic Characteristics

a. For the disabled population in your estimate:

1) Number;
2) Unemployment Rate;
3) Average Salary; and
4) Average Income.

b. What changes, if any, are being projected for the figures under 1.a. above?
c. How will these changes affect your program?

2. Economic Environment

a. What are the economic trends at the national and local levels (unemployment rate, inflation rate, etc.)?
b. How do these trends affect numbers and types of available jobs? placement rates?
c. What actions (i) have been (ii) could be taken by the managers of your program in view of these trends?
d. What are the economic incentives and disincentives affecting clients' willingness to work?

3. Political Environment

a. How do current political trends affect (i) the development of new jobs; and (ii) the preparation of clients for employment?
b. How does current legislation affect the program? Are changes in legislation foreseen? If so, how might these changes affect your program?
c. Is your program associated with any professional, voluntary, trade, etc., organizations that can influence legislation affecting the program. If so, list:

1) local organizations;
2) state organizations;
3) regional organizations; and
4) national organizations.

4. Technological Environment

a. What kinds of jobs are no longer available because of recent technological advances? What kinds of skills are no longer needed or useful?
b. What kinds of new jobs are emerging as a result of new technologies?
c. How are these new skills acquired (for example, through on-the-job training, classroom instruction, apprenticeship, etc.)?

5. Physical Environment

a. Have accessibility surveys been conducted in the community?
b. On the whole, is the working environment accessible to disabled people?
c. What types of transportation are available in the community?

B. Program Environment

1. Publics (i.e., distinct groups of people or organizations that have an interest or impact on your program [cf. Kotler, 1982]; e.g., business and professional groups, trade associations, regulatory agencies, media, governmental agencies, etc.).

a. List your main publics.
b. Are the program's mission and objectives well known to your publics?

2. Markets (i.e., publics with whom you wish to exchange resources such as services, goods, funds, etc.; e.g., employers, referral agents, client groups, state rehabilitation agencies, etc.).

a. List your current markets.
b. How is your program perceived by these markets?
c. Do you have plans to develop new markets?

3. Consumers

a. Who are the major consumers of your services?
b. What are their needs? What major changes in these needs are being anticipated?
c. Who might be potential consumers of your services?
d. How does the program contact prospective consumers?

4. Facilitators

   a. What accessibility regulations govern your program (e.g., Sections 502 and 504 of the 1973 Rehabilitation Act; state building codes, etc.)? Is your program in compliance with these regulations?
   b. What special transportation services are available to the program?
   c. List referral sources for the program.
   d. How are referrals made?
   e. List funding resources.
   f. What changes in any of the above are you anticipating? How might these changes affect your program?

5. Competitors

   a. Who are your major competitors?
   b. What strategies have you developed to monitor trends in competition over time?
   c. What differentiates this program from its competitors? What makes it distinctive?
   d. What is the program doing to improve its relative position with respect to competitors?

6. Staff

   a. Do the members of your staff understand and accept the marketing concept?
   b. Do they have the necessary skills to implement marketing practices? What special training, supervision, and/or incentives are needed?

III. Services

A. List the major services offered and complete the following table for each of those services. Identify strengths and weaknesses.

   1. Service;
   2. Average number of clients per month;
   3. Cost of unit or service per client;
   4. Strengths;
   5. Weaknesses;
   6. Overlap with other services (yes/no).

B. How can services be improved? List each service and needed improvement(s).

Service	Improvement
_____	_____
_____	_____
_____	_____

C. Have any new services been planned for the future?

Yes _____ No _____

If yes, list the planned services and for each service project the following:

1. Service;
2. Estimated average number of clients per month;
3. Estimated cost per unit; and
4. Potential problems/difficulties.

D. What services should be phased out?

E. Pressures (economic, political, social, etc.) that may affect service quality;

1. Nature of pressure;
2. Source of pressure;
3. Impact upon service quality; and
4. Possible solutions for problems created by pressure.

F. Is your program providing any services to non-clients?

Yes _____ No _____

If yes, check the non-client groups and/or individuals that you are serving. For each group or individual, indicate in the table below the nature of the service(s) you are providing, etc.:

1. Assistance in developing affirmative action plans;
2. Consultation regarding accessibility;
3. Educational and informational presentations;
4. Information and referral;
5. Consultation regarding tax incentives for hiring disabled persons;
6. Consultation regarding restructuring the environmental modifications;
7. Other (specify).

Non-Client Service Recipients (check all that apply)	Type of Services Provided
Employers	
Other Industry Business Groups (specify)	
Civic Organizations	
Clients' Families	
Transportation Firms	
Architects	
Educational Institutions	
Local Government Officials	
Others (specify)	

IV. Pricing

A. Describe the procedures used to establish and review pricing policy.

B. Is pricing determined by (check all that apply):

	Yes	No
Income level of client	___	___
Frequency of service used by client	___	___
Time of use	___	___
Duration of services (number of sessions)	___	___
Type of service	___	___
Client's level of disability	___	___
Other (specify)	___	___

C. Are consumers, under certain circumstances, entitled to reduced fees for services? If so, (1) specify these circumstances; (2) indicate which of the following mechanisms are used:

1. Sliding fee scale _____
2. Federal subsidy _____
3. Discounts offered to special groups _____
4. Waiver of charges _____
5. Other (specify) _____

D. Which of the following types of payments are accepted? (Check all that apply.)

1. Third part _____
2. Credit account _____
3. Cash _____
4. Other (specify) _____

E. Are refunds offered? If so, under what conditions?

V. Marketing Practices

A. Public Relations

1. Who is responsible for public relations for the program?

   a. Is the position full-time or part-time?
   b. If part-time, what percentage of time is spent on public relations?

2. List your program's public relations activities.
3. What percentage of the staff is actively involved in civic organizations?
4. How is the effectiveness of your public relations evaluated?

B. Promotion and Advertising

1. Who is responsible for promotion?
2. List the objectives for promotion.
3. What media are used for promotion? Check all that apply:

   a. Newspapers and magazines ____
   b. Radio and TV ____
   c. Church bulletins, newsletters, business house organs ____
   d. School catalogues ____
   e. Telephone directories (yellow pages) ____
   f. Exhibitions, billboards, posters ____
   g. Direct mail ____
   h. Presentations of community groups ____
   i. Other ____

4. How are inquiries resulting from promotion handled and followed up?
5. How is the promotion and advertising program evaluated? (Hawley, Grant, Haqq, Jiang, & Montesinos, 1983).

APPENDIX E

Basic Counselor Techniques for Effective Case Management

1. Have packets prepared containing all items that could be used at the initial interview including:

   * Client case record
   * Release of information forms
   * Any agency brochures
   * Business card(s)
   * Appropriate agency forms
   * Pertinent information on available resources

2. Pre-interview forms (Examples)

   * Use with referral sources

3. If an appointment letter is sent, give the time, the date, and the location for the initial interview.

   * You might want to include a pre-interview form and a copy of your agency brochure.

4. Maintain an office file that shows referral sources and the counselor working each referral source.

   * Helpful in aiding someone else to obtain needed information from a referral source.

5. The local office would maintain an up-to-date list of doctors who do general medicals and specialist exams for the agency.

   * These doctors would be rated by the staff on how quickly appointments could be made, the caliber of their reports, the speed of their sending the reports, etc.

6. The district office would maintain a list of community resources and discuss these periodically in staff meetings.

Initial Interview Techniques

1. Listen, try to discover what the applicant really wants and/or expects from Vocational Rehabilitation (VR).

2. Explain your agency brochure thoroughly to the applicant.

   * Be sure the applicant understands VR services.
   * Be careful of the use of VR jargon.

3. Stress that employment is the end goal of any services that might be provided.

   * Ask the question: "What can VR provide that will enable you (to return) to work?

4. Make certain to get telephone numbers and addresses of sources that can be contracted.

5. Determine when to "pull out" and complete the application.

6. Issue any necessary paperwork for information after application is completed.

7. Give the client specific things to do and/or accomplish before his/her next visit.

8. Each counselor should be certain that the applicant knows the counselor's "personal rules" for his/her clients.

9. Write the days and times that you would prefer to be contacted by telephone on the back of your business card.

10. Have a checklist for case movement.

11. Determine which services the client needs.

12. Record needed date - references, employment history.

13. Explain "VR Process" to client - length of time, etc.

Management Techniques for Status 02
(Applicant Status)

1. Contact the client the day before a scheduled medical appointment, etc. to verify that the appointment will be kept.

   * Secretary should do this.
   * Use a "suspense file" or calendar to trigger the calls.

2. Send a narrative type letter to medical specialists and other service providers explaining what is needed on the report of the examination or other services rendered.

3. As soon as a counselor anticipates that some type of training and/or evaluation might be involved in a case, there are several things that he/she should begin to check into:

   * Transportation, financial situation, home situation, babysitters, Pell grant applications, etc.
   * A checklist might be appropriate for this.

4. Concept of "job ready" before a client enters a training program. What are some indicators?

5. Caution must be used when counseling and/or writing a client, telling him/her that he/she is eligible for services.

   * It is advisable to indicate that the possibility of services exists.

6. Explain the client's responsibility for maintaining contacts with the counselor.

   * Try to establish this routine as quickly as possible.

7. Reports of contact - next action - review cases frequently.

8. Checklist for case management.

Management Techniques for Status 06
(Extended Evaluation)

1. Know what functional limitations you are addressing with each client.

2. Make sure the client understands that services provided in status 06 are to determine whether or not he/she is eligible for services.

3. To effectively utilize available resources requires both time management skills and knowledge of support services within the community.

4. Personal contacts with the client should be made on a regular basis at the facility.

5. When securing a starting date, be certain to allow yourself time to write the plan and to get the paperwork to the vendor.

   * Don't be pushed by the facility and/or the client into a starting date that will not allow enough time to complete the required paperwork.

6. Maintain a list (file) of clients entering evaluation including starting and ending dates.

   * Helpful when scheduling visits
   * Might be able to use files to accomplish this

7. Know the facility counselor(s) for your client(s) and maintain contact with him/her/them.

8. Know when services are offered by a facility and what each service is supposed to accomplish.

* Facility listing sheets.
* Personality of each facility and the types of clients each facility works well.

9. Explain thoroughly to the clients why they are going to a facility and what results are anticipated.

   * Checklist?

10. Explain to the clients what they can expect the first day of the evaluation and what they can expect during the first week.

    * Checklist?

Management Techniques for Status 10-18

10 -- Program Development
12 -- Program Preparation Completed
14 -- Counseling and Guidance
16 -- Physical and Mental Restoration
18 -- Training

1. Make personal contacts on a regular basis.

   * If the client is receiving services where it is impossible for you to visit, have the client write at least once a month.

2. When securing a starting date for services, allow enough time to write the plan and get the authorization to the vendor.

   * Don't be pushed by the vendor and/or the client into a starting date that will not allow enough time to complete the required paperwork.

3. Maintain a "tracking" system of clients with the starting and ending dates.

   * Helpful when scheduling visits.
   * Secretaries could help maintain the system.

4. Most problems that a client experiences while in training will occur during the first two months. This makes a personal visit with the client during the first three weeks of training very important.

5. Color ode case file tabs according to the service being provided: vocational school, college, guidance and counseling, etc.

   * Small colored metal tabs could be used.

6. Checklist for cases entering training - actions needed

   * What should be on the checklist?

Management Techniques for Status 20-24

20 -- Ready for Employment
22 -- In Employment
24 -- Services Interrupted

1. Procedures that could be used to locate a "lost" client:

   * Get good contact references on the application at initial interview.
   * Use cross-reference books (phone numbers/street addresses) in districts where the books are available.
   * Call clients from your home during non-working hours.
   * Give clients positive "strokes" just before they complete a training program.
   * Make home visit.
   * Job service computer for employment in state.
   * Contact school client attended.
   * Don't close case when client fails to answer letter or phone.

Management Techniques for Status 32
(Post Employment Services)

1. Make sure the solution to the problem does not entail a complex or comprehensive rehabilitation effort.

2. Determine whether the services relate to the original disability on which eligibility was based.

   * Determine whether the services are necessary to assist the individual in maintaining employment, or
   * Services leading to placement at a new job will not conflict with item 1 above.

3. Follow-up to be sure client receives services as planned.

4. Document progress as necessary.

General Case Management Techniques

1. Handle mail and/or papers only once.

   * Use file trays to place papers according to action to be taken

2. Filing system.

   * File cases alphabetically within statuses 00-02, 06, 10-18, 20, 22, and 24.
   * Have a special area for cases that are ready for action.

3. Advantages of a monthly calendar versus a daily desk type.

4. Use of a 30-day suspense-file system to aid in organizing work.

5. Review all case files once a month and make notes for actions to do on cases for the next month.

    * Might want to do this every two weeks for "02" cases.

6. Keep notes in a steno pad or spiral notebook rather than on loose sheets to prevent losing the notes.

    * "Things to do" list.

7. Model work week. What is a model week?

8. Use the last half hour of each day to file and arrange work for the following day.

9. Plan field days so that travel is not haphazard.

    * Plan extra contacts if time is available.
    * Notify schools, facilities and/or referral sources when you plan to visit.
    * Begin and/or end each field day in the office.

10. Provide feedback to referral sources.

    * VR-1 referral & feedback form
    * Carbon of letters to clients
    * Closing of case

11. Rolodex file can be used to keep telephone numbers and addresses readily available.

12. Keep a supply of forms in desk drawer.

13. What a counselor should take with him/her on a field day.

APPENDIX F

COOPERATIVE AGREEMENT
BETWEEN
MARTHA WALKER COMMUNITY CENTER
AND
VOCATIONAL REHABILITATION

INTRODUCTION

Martha Walker is a church related, board governed, social and recreational community center. The center has served the needy, the handicapped and the poverty stricken people living in the John C. Smith Homes inner city area for the past 50 years.

During the past several years vocational rehabilitation and Martha Walker Community Center have worked together in an informal manner to enhance opportunities and experiences for the handicapped residents in the community served by Martha Walker.

PURPOSE

The purpose of this agreement is for vocational rehabilitation/Martha Walker to work together on a formal basis to provide a pattern of services for the disabled living in the area which will appreciably affect the person's total development.

More specifically, the objectives are: (Again, from a "total development" standpoint).

1. To improve individual and family life styles through extending the environmental alternatives.

2. To provide services not readily available in the community.

3. To foster individual growth through providing an atmosphere where individual freedoms and needs are recognized.

4. To provide an atmosphere of acceptance where positive self-concepts would be stressed through the recognition of individual worth and the expression of individual views.

5. To help coordinate other agency services in the community.

AGENCY RESPONSIBILITY

In order to achieve these objectives, vocational rehabilitation will:

1. Place appropriate staff in the Martha Walker Center at no cost for rent purposes but pay for phone service and all other staff needs.

2. Coordinate all vocational rehabilitation services with the Martha Walker Center (and other community agencies) to remove duplication and increase cooperation.

3. Purchase available support services for clients from the Martha Walker Center where not obtainable through similar benefits, such as:

   a. Child care (baby sitting)
   b. Transportation
   c. Attendant care
   d. Etc.

4. Work with Center staff and others in promoting job development and job placement for the handicapped.

5. Establish in cooperation with Martha Walker Center a referral and outreach program for the residents in the specified area.

6. Develop a public awareness program in meeting the needs of this group in coordination with other community agencies.

7. Help develop a volunteer service group both <u>within</u> and outside the immediate area.

Martha Walker Center will provide the following services in accordance with this agreement:

1. Child Development Component

   a. Day Care - Developmental day care program for children of working mothers. Ages 2-5 served from 6:00 am - 5:30 pm. Maximum slots 44.
   b. Pre-School - Half-day program for children of nonworking mothers. Ages 3-5 from 9:00 am - 12:00 noon. Maximum slots 15.

2. Recreation Services - A program designed to offer opportunties to individuals and groups for constructive and satisfying use of their time through a variety or recreational services. However, it is important to understand that the main emphasis of these activities is to promote sound personality development of the participants.

3. Adult Services

   a. Transportation - A 12-passenger van is operated daily by the Center from 7:30 am - 3:30 pm, taking people who live on limited incomes to the doctors' offices, public health clinic, welfare office, social security office, food stamp office and the like.

b. Auxiliary Services - This component provides a variety of auxiliary services to adults, i.e., adult education, income tax assistance, supplemental food.

4. Social Services - Provides a variety of social services to the families and individuals who are involved with the Center. These services include assistance with such needs as:

   a. Health problems
   b. Financial problems
   c. Emotional or psychological problems
   d. Information and referral

STAFF DEVELOPMENT

Vocational rehabilitation and Martha Walker staff will coordinate their efforts for providing in-service training to both staffs on a planned and continuing basis to enhance meeting logical needs of clients in a prompt manner.

TERMS OF AGREEMENT

In view of the uniqueness (public agency and private agency) of this agreement and the circumstances under which it was developed--in spirit as opposed to meeting an "intent"--either party can discontinue its participation upon notification.

_____	_____
Date	Commissioner Vocational Rehabilitation
_____	_____
Date	Board Chairperson Martha Walker Center

APPENDIX G

THE VALLEY PROJECT
A Summary

Principal Authors:

Joellen Simmons, Assistant Deputy Commissioner
Texas Rehabilitation Commission

Frank Perdue, Director
Transition Programs
Texas Rehabilitation Commission

Roger Webb, Director
Texas Planning Council for Developmental Disabilities

Milton Lege', Director
Extended Rehabilitation Services
Texas Rehabilitation Commission

Eleanor Mikulin, Education Specialist
Texas Education Agency

The "Valley Project" is a demonstration of multi-agency services which was cooperatively developed in response to Senate Concurrent Resolution (SCR) 129 and is considered as a model for transitional services from school to community and institution to community. The model is the prototype of services for the future and is currently piloted in Brownsville, Edinburg, McAllen, and Laredo schools.

SCR 129, passed in the 69th Legislature, mandated cooperation among Texas Education Agency (TEA), Texas Rehabilitation Commission (TRC), and Texas Department of Mental Health and Mental Retardation (TDMHMR) in the transition of students who are mentally retarded (see attached). The Valley project, however, is not limited to persons who are mentally retarded, but it is an effort to demonstrate how services from TEA, TDMHMR, and TRC can be coordinated to provide quality transitional services as related in the interagency agreement signed in response to SCR 129.

Prior to SCR 129, TRC and TEA were cooperatively addressing another issue related to the lack of state matching funds needed for vocational education federal funds in the lower Texas Valley (Carl Perkins Act). TRC approached TEA after discovering there was a need for state and local funds to draw down the vocational educational funding from the Carl Perkins Act in response to local consumers in the Valley area as well as TRC's desire to re-focus transitional services in a cooperative manner. (Cooperative school programs began in the late sixties but were discontinued due to a direction from OMB in 1976.) After collaborating, TEA agreed to approve a unique approach for local schools to provide vocational education using state funds provided by TRC through a transitioning concept.

On September 1, 1986, Governor Mark White responded to TRC by providing state matching funds of $200,000 (earned federal funds) after learning about the needs of the Valley area. The funds are targeted by TRC to provide vocational rehabilitation services for public school students in vocational education who are disadvantaged. This opportunity for supplemental state funds/services will allow TRC to provide matching funds on behalf of local education from the Carl Perkins Act. The matching funds will allow TRC to supplement the vocational services of students by allowing TRC to purchase or provide special training to assist the students to transition into employment and the community. This was the first step of interagency coordination as reflected in SCR 129.

The concept of the Valley Project is that TRC, TEA, and TDMHMR agree to cooperatively cluster respective services in a geographic area whereby consumers are able to transition from schools to the community while continuing to receive appropriate services for which they are eligible.

The transition will require that agencies transfer their responsibilities of financial support rather than forcing persons with disabilities/handicaps to physically move due to financial funding eligibility regulations and laws.

Ideally, the consumer will have received the benefit of interagency collaboration through cooperative planning of agencies responsible to deliver services prior to any changes in the programs.

Generally, formal planning will occur during the high school years when the person who is handicapped still has access to education prior to graduation. Special education students are required to have comprehensive assessments every three years and must be annually reviewed; therefore, a progression of planning meetings is already in place for schools to request agencies to cooperatively plan services for its students.

This also would be appropriate for students who are handicapped and in need of vocational education services in which planning is required through an Admission Review and Dismissal (ARD) assessment/process or for those who require additional planning for students in need of TRC or TDMHMR services on a local level who are not currently receiving such programs. (Examples are: a student in regular programs who is disabled but needs TRC services as an assistance for entry into college as a result of his/her disability which affects employment opportunities; a regular student who is disabled but graduating into the community, needing accommodations on the job.)

Those schools that have students who do receive special education services in high school should initiate annual data gathering of the number of its students in need of transitional services. In order to do this, schools should document a cumulative "statistical" report that indicates how many students will need services from TRC or TDMHMR (or other appropriate community services). By sharing information, agencies can proactively plan respective services and effectively budget in advance of the request for actual services. The Valley Project (SCR 129 concept) will call upon schools to expand responsibilities in the area of assessment. Responsible schools will collect and provide eligibility assessment data prior to referral to other agencies' services (subcontracts are appropriate prior to age 22) for persons with handicaps.

The general idea is that public school programs in special education or vocational education will "comprehensively assess" in order to obtain services provided by other agencies. The data will allow TRC or TDMHMR to determine eligibility for respective services and to plan with the district cooperatively for the implementation of such services prior to age 22. The provision of the assessment by the public schools allows the student to remain in current services with little interruption and allows sharing of diagnostic information which will in effect result in an orderly and timely progression of multiple services.

(An example would be for an 18-year-old student who is handicapped to have completed special education curriculum and vocational readiness skills, to have been assessed for TRC vocational rehabilitation services needed at age 22, and for the appropriate school program to place and concurrently provide services prior to age 22, which may include a subcontract for services.)

Planning for the transitional process should not occur later than age 16. It should be noted that each school participating in this project will be expected to sign a multi-agency agreement for clarifying roles and responsibilities. It is expected that districts that have students ready for transition prior to the age of 22 will provide or subcontract for such services in the most appropriate and least restrictive environment and that although the confidentiality of students is to be retained, districts are authorized by Public Law 94-142 to share names of students and information necessary to develop, provide, implement, and follow-up education services to students. School districts are encouraged to judiciously process such information in order that the planning and sharing of confidential information does not slow down or disrupt the students' education process.

Districts have available various funds they may utilize including, but not limited to, vocational education funding (state/federal) and special education (state/federal). When program guidelines and policies require an array of personnel to be present with the student, the projects have the flexibility of providing such personnel (certified vocational teacher or any designated special service personnel), and/or districts have the liberty of placing their own personnel off-campus within facilities or with students in order to provide appropriate supervision and/or instruction to maintain ADA and accountability.

This project will offer an array of services (a menu of selection) which schools within their planning process may consider as transitional services. Schools are responsible for the referral process prior to age 22 and to provide referral and assessments/collation of information for agencies on behalf of its students.

Vocational Education Transitional Services

In order to count the program/service as a vocational education service whenever the district selects a service for the transitioning process, the following must be present:

* Vocational education directors and TRC vocational rehabilitation counselors are concurrently responsible for the student (this may include the provision of multiple services from various agencies or programs.)

* When off-campus, vocational education teachers are available to provide off-campus supervision of each student regardless of whether on-the-job training or receiving services within another community services facility (for special education students, the ARD/IEP must designate the number of hours of supervision recognizing each service will require a flexible schedule).

* Students must be enrolled in vocational education and be eligible for vocational rehabilitation services (students may be enrolled in vocational education and provided services from other service providers in the community).

* If the district is utilizing the TRC state funds or "matching funds" for Carl Perkins Vocational Education Act funds, the district must receive direct funding for services for students who are handicapped or in vocational education or count in-kind services for disadvantaged/vocational education students. Since TRC has set aside a specific allocation to each district (a proportionate match required for the Carl Perkins Act), the vocational education director may proceed to utilize its federal funding when providing supplemental transitional services for its students.

TEA has indicated to TRC that vocational rehabilitation counselors utilizing state funds for services for students must document and furnish on a quarterly basis (September 30, December 31, March 31, June 30) the following information:

* Each student identified by a social security number;

* Each service provided;

* Exact dollar amount of the services; and

* Time and effort equal to a dollar amount IF CAREER and GUIDANCE IS PROVIDED (timetable per counselor).

Information must also be reflected with the IWRP or subsequent contact reports in cases of a federal audit for vocational education funding. Vocational rehabilitation counselors will need to closely coordinate with schools to verify that each student is handicapped and disadvantaged by TEA criteria and that they are in a bona fide vocational education program when TRC services are provided, such as VEH, CVAE, or IVE.

If extended rehabilitation services (ERS) are selected for vocational education and special education students, the IEP must include goals for movement to the least restrictive services and environment. (Supported work, work enclaves, job coach, etc., or services of ERS as well as several other agencies.)

Special Education Transitional Services

Students who are handicapped must have transitional services selected during the ARD committee meeting with the coordination of the TRC vocational rehabilitation counselor:

* Special education students are to continue enrollment for ADA up to age 22 or graduation.

* Special education personnel may be designated for off-campus concurrent instruction and supervision with other services and be considered for community instructional arrangements or other appropriate arrangements as necessary (includes TRC services, local MHMR, or DD projects related to employment).

* Parents/guardians are to be encouraged to make onsite visits of services and provide feedback during the course of services that will affect continued quality services as well as to be assisted to contact appropriate community agencies for long-term care and planning of lifetime services (i.e., social security, housing, transportation, accessible services, respite care, case management, recreational services, etc.)

* The IEP must designate movement towards the least restrictive environment which allows the student to progress appropriately into supported or competitive work.

* Follow-up must be provided one year after successful placement of employment to be arranged by the district but may be provided by another service provider. Documentation of the follow-up will include client/parental satisfaction of services, other services needed by the client, etc. Any constructive input as to how to better service or provide additional services not available shall be summarily reported on an annual basis to the local advisory committee of the Valley Project in order that adjustments may be considered.

The following are recommended as guidance for options that may be considered by the local district:

SENATE CONCURRENT RESOLUTION #129

AS FINALLY PASSED AND SENT TO THE GOVERNOR
BY THE
69TH LEGISLATURE OF THE STATE OF TEXAS

Whereas, Recognizing that cooperation among the Texas Department of Mental Health and Mental Retardation, the Texas Rehabilitation Commission, and the Central Education Agency is required to provide an appropriate array of vocational and educational services to persons with mental retardation; and

Whereas, The present organization of the service delivery system creates difficulty in maintaining a continuous flow of services to persons with mental retardation; and

Whereas, There are currently unnecessary duplication of services, barriers to services and inefficiencies in the delivery of the needed services; and

Whereas, Facilitation of the sharing of diagnostic services among these agencies would streamline entry into services and represent a cost savings to the state; and

Whereas, Coordination to the transition point when persons leave the services of the public school system and require access to services of the other agencies is particularly important; now, therefore, be it

Resolved, That the 69th Legislature of the State of Texas hereby request the cooperation of the Texas Department of Mental Health and Mental Retardation, the Central Education Agency, and the Texas Rehabilitation Commission in implementing the recommendation of the Legislative Oversight Committee on Mental Health and Mental Retardation to improve coordination of their services to persons with mental retardation; and, be it further

Resolved, That the Texas Department of Mental Health and Mental Retardation, the Central Education Agency, and the Texas Rehabilitation Commission be directed to work collaboratively to initiate joint agreements concerning the provision of educational, vocational, and other services to persons with mental retardation in order to facilitate the transition from educational to vocational rehabilitation services or Texas Department of Mental Health and Mental Retardation services and to encourage services and to encourage the streamlining of entry into their various services through shared diagnostic information; and be it further

Resolved, That an official copy of this resolution be prepared and forwarded to the commissioner of the Texas Department of Mental Health and Mental Retardation, the commissioner of the Central Education Agency, and the commissioner of the Texas Rehabilitation Commission as an expression of the wishes of the Legislature.

VALLEY PROJECTS

COORDINATED PROGRAM OF TRANSITION SERVICES FOR HANDICAPPED STUDENTS/CLIENTS BY:

- Independent School Districts

  Brownsville ISD
  Edinburg ISD
  McAllen ISD
  Laredo ISD

- Texas Education Agency

  Special Education
  Vocational Education

- Texas Rehabilitation Commission

- Texas Department of Mental Health and Mental Retardation

- Tropical Texas MHMR Center

- Laredo State Center

PROJECT COMPONENTS

TRANSITION SERVICES FROM PUBLIC SCHOOL PROGRAMS TO:

- Continuous Employment

  Supported Employment
  Competitive Employment with Support
  Competitive Employment without Support
  Enclaves in Industry
  Mobile Crews
  Job Coaching
  Sheltered Workshops
  Work Activity Centers

- Extended Rehabilitation Services

- Adult Activity

  Pre-Vocational Training
  Pre-ERS Training

MULTIDIMENSIONAL SUPPORT

- Persons who are not currently eligible for ERS services.
- ARD committee determines need for this service.
- For individuals with developmental disabilities ages 16 and older who have not demonstrated the ability to produce at greater than or equal to 15% of competitive wages.
- All persons with developmental disabilities as defined by P.L. 98-527 are eligible program participants. While the primary goal of the program is to enable participants to achieve a functional vocational level which would enable them to move into a sheltered or supported work program, individuals who do not attain this goal shall not be excluded from continuing in the program.
- To demonstrate the vocational potential and/or potential for personal independence of individuals with developmental disabilities when given access to an appropriate multidimensional training program.
- To stimulate the restructuring of existing programs and/or development of new programs focusing on independent living skill development, transitioning to vocational services and job placement.

FUNDING SOURCES

- $200,000 State funds (TRC) for VR services:

  D and E
  Job Readiness
  Vocational Counseling and Guidance
  Other

- VR services (funds) to handicapped/disadvantaged students in VEH, CVAE, and IVE used to match Carl Perkins Vocational Education federal funds by LEA.

- Schools use matched dollars to enrich existing vocational education program allowing better "transitioning."

- Special Education funds for students to be placed in Community Instructional Classes:

  ERS
  Independent Living
  Adult Day Services

- Persons above age 22 transitioned into:

  ERS
  VR
  Adult Activity

ADDITIONAL COPIES

Multidisciplinary Approach to Rehabilitation

07-1381 ..... $ 6.00

Arkansas Research and Training Center in Vocational Rehabilitation

Publications Department
Post Office Box 1358
Hot Springs, Arkansas 71902